

# **PROVIDING INTEGRATED AND TEEN-FRIENDLY REPRODUCTIVE HEALTH SERVICES:**

## **How to Assess and Strengthen Your Service Interventions**

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Virginia S. Loo, Ph.D.  
Claire D. Brindis, Dr.P.H.  
Gail A. Bolan, M.D.

California Department of Health Services  
Sexually Transmitted Disease Control Branch  
&  
The Bixby Center for Global Reproductive Health  
University of California, San Francisco  
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## Preface

Integrated service delivery and increasing teen friendliness are two strategies recommended in national guidelines to improve adolescent health.<sup>1 2</sup> These strategies are particularly relevant for better utilization of sensitive services for sexually transmitted infections (STIs), HIV, and family planning. In an effort to better understand how to connect the national guidelines with improved, more teen-friendly services for adolescents' reproductive health, we conducted a review of available sensitive services within one community and their level of integration.

To better understand the many facets of service integration and teen friendliness, we talked to over 110 experts in the field of adolescent services: program administrators, providers, and their adolescent clients. Not surprisingly, we found a diverse range of integrated service delivery models being implemented.

### **The two goals of this guidebook are:**

- ① To provide a program assessment framework for determining how integrated and teen friendly services are, and
- ② To provide tools for planning viable next steps for those programs that want to achieve higher levels of service integration and teen friendliness.

If you are...

### **Who Should Read this Guidebook?**

A program administrator or staff member of a reproductive health program,  
A policymaker, program planner, or health educator in a local health department, or  
A member of a community group or coalition interested in adolescent health

...this Guidebook was written for you.

### **How this Guidebook is Organized**

Program assessments can be conducted at an individual program level or on a community-wide basis. In this Guidebook, we provide step-by-step instructions



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<sup>1</sup> These include the national guidelines from: (1) National Center for Education in Maternal and Child Bright Futures for Health Supervision of Infants, Children and Adolescents, (2) the U.S. Preventive Services Taskforce's Guide to Clinical Preventive Services, and (3) the American Medical Association's Guidelines for Adolescent Preventive Services. See the Resources section of the Appendices for more information.

<sup>2</sup> Adolescents and young adults defined as ranging from 10-24 years of age.

for completing both types of assessments. Sections of this Guidebook that are specific to community-wide assessments are highlighted by this symbol:

At both the individual and community levels we encourage the active involvement of direct service providers, program administrators, and teens to participate in the assessment and planning efforts that build upon your findings. In developing this assessment framework, we designed an approach that solicits feedback from the multiple perspectives that can best inform efforts to improve adolescent health service delivery. We encourage program staff to consider the range of potential strategies available to them that could result in substantial enhancements in their current efforts to serve adolescents.

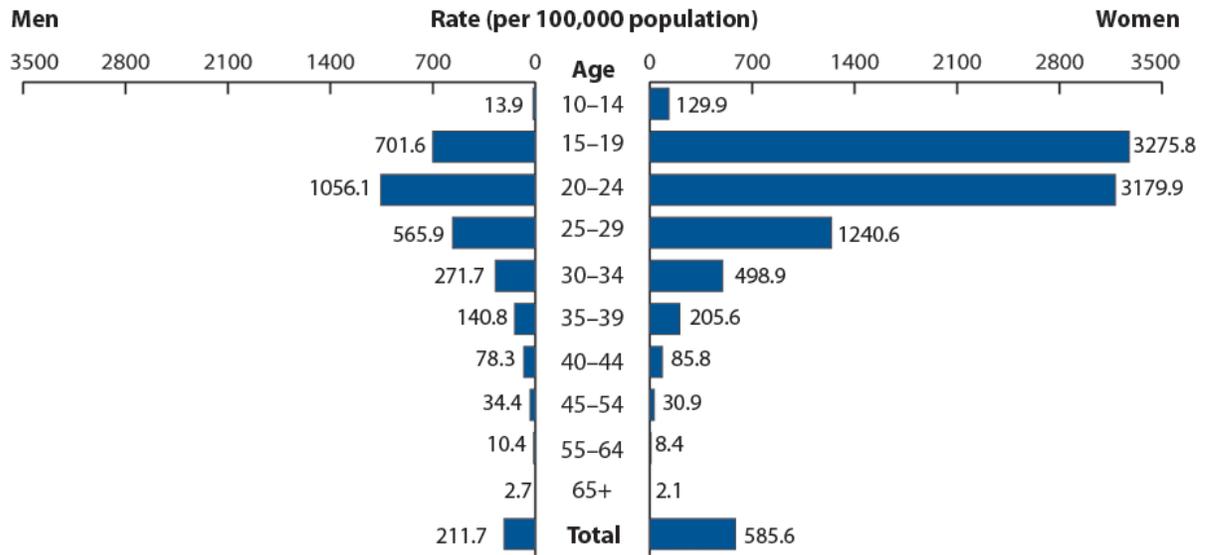
Our interest in implementing integrated services, teen-friendliness, and the relationship between the two is ongoing. Because we are evolving in our approaches to better serving youth, we hope that the promotion of both individual program and community-wide assessments may generate future opportunities to share insights with other professionals providing sexual and reproductive health services for adolescents.

## Overview of Adolescent Sexual Health

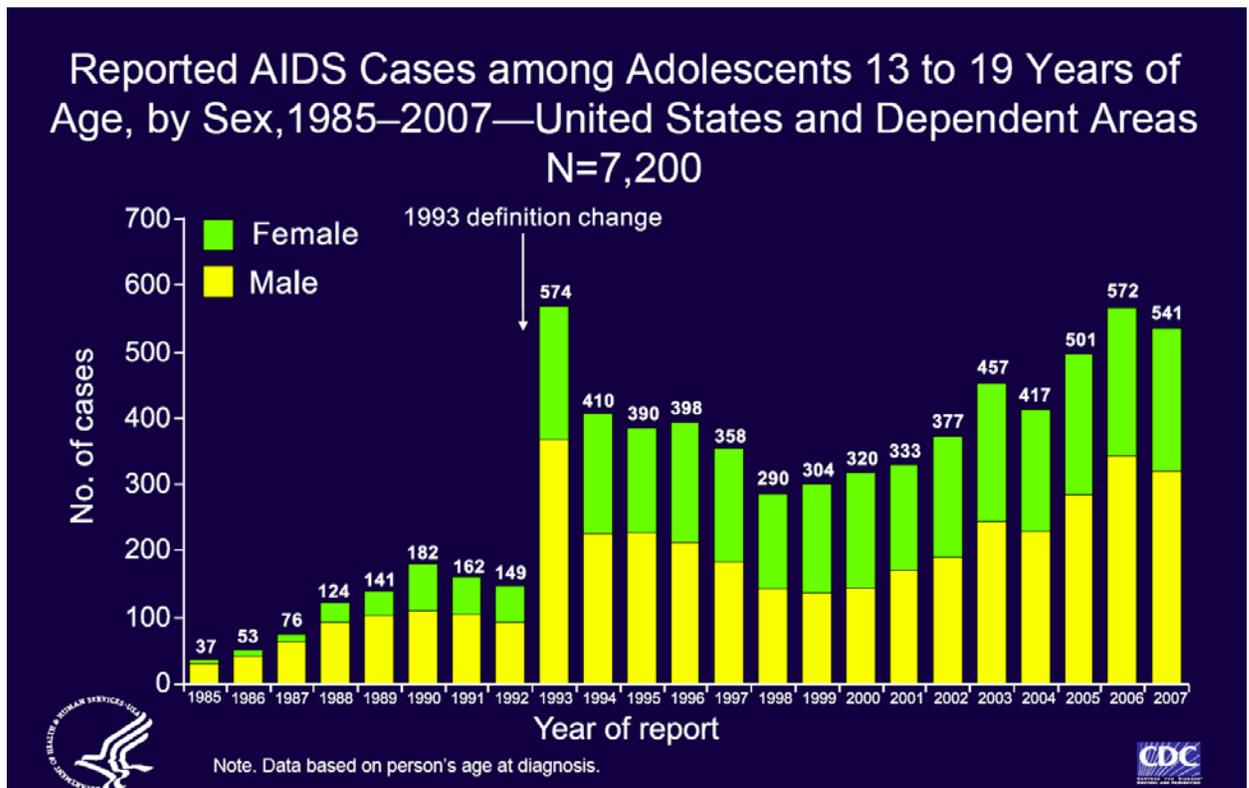
Sexual and reproductive health services are critical for adolescents, one of the highest risk groups for sexually transmitted infections (STIs) and unintended pregnancies in the United States. The following facts speak for themselves:

- Although adolescent birth rates in the U.S. have declined over the past two decades, the current rate of 41.5 births per 1000 women ages 15 to 19 in 2008 remains the highest of all other industrialized countries (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2010).
- Females ages 15-19 have the highest rate of chlamydia of all other age-sex groups at 3275 cases reported per 100,000 in 2008 (Center for Disease Control and Prevention, 2009).
- Adolescents infected with herpes, gonorrhea, or chlamydia compound their risk for acquiring HIV due to increased biological susceptibility and selection of higher risk sexual partners (Center for Disease Control and Prevention, 2002).
- The annual number of AIDS cases reported has increased among adolescents aged 13-19 from 290 in 1998 to 541 in 2007 (Centers for Disease Control and Prevention, 2009).

**Chlamydia – Age- and sex-specific rates: United States, 2008**



Source: Centers for Disease Control and Prevention. *Sexually Transmitted Diseases Surveillance, 2008*. Atlanta, GA: U.S. Department of Health and Human Services; November 2009. Available at: <http://www.cdc.gov/std/stats08/toc.htm>.



Source: Centers for Disease Control and Prevention. *HIV/AIDS Surveillance in Adolescents and Young Adults (through 2007)*. Atlanta, GA: U.S. Department of Health and Human Services; May 2009. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/adolescents/index.htm>

According to the Centers for Disease Control (CDC, 2001), routine STI screening for males and females is particularly important to protect female adolescents' future reproductive health.<sup>3</sup> The CDC reported the following:

As many as 75% of chlamydia infections among women may occur without noticeable symptoms; these infections may go undetected for many months.

In approximately 40% of all cases, untreated chlamydial infections will develop into pelvic inflammatory disease (PID) that may lead to ectopic pregnancy or infertility.

Re-infection among adolescents is also more likely if their partners are not notified and treated in a timely manner.

Accessibility and a high level of trust are important issues in the provision of sexual and reproductive health services for adolescents, as evidenced by the following:

In a study of adolescent sexual health, 27% of participating high school students reported not having sought care when they needed it. Of those who sought care, only 43% of females and 26% of males discussed STI or pregnancy prevention with their provider during their most recent visit (Klein, Wilson, McNulty, Kappahn, Collins, 1999).

Given the profile of adolescent sexual risk-taking behavior, primary prevention programs (those that provide comprehensive health education to adolescents as well as access to contraceptive information and services), and secondary prevention services (those that provide screening and risk reduction counseling) have the potential for meeting the needs of many young people. These efforts aim at providing adolescents with the critical life-long skills necessary to support positive health behaviors.

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<sup>3</sup> The terms 'Sexually Transmitted Diseases' and 'Sexually Transmitted Infections' are virtually interchangeable today. Historically, many health departments' STD Control Branches dealt with diseases such as syphilis, gonorrhea, and chancroid. In the last decade, more attention has been paid to chlamydia, genital herpes, human papilloma virus, and hepatitis B and C, which may not cause immediate symptoms, but do contribute to long term sequelae among patients. Today, the term 'infections' may be a more accurate description of the collection of pathogens of concern. In this Guidebook, we use the term 'Sexually Transmitted Infections' (STIs) except when referring to specific programs or offices that continue to use the term 'Sexually Transmitted Diseases' (STDs).

## Defining an Integrated, Teen-friendly Program

### **What do we mean by integrated services?**

The definition we adopt in this guide considers full integration from a client's perspective. In other words:

When a client comes to a clinic or to a primary prevention program, provider(s) proactively offer adolescents services in three areas: STIs, HIV, and family planning, even if a client seeks care in one specific issue.

These services may include counseling, screening, education, treatment, and/or supplies.

The full range of STI, HIV, and family planning services are available to adolescent clients during the same visit.

This definition represents an ideal to strive for, but may not be realistic for all programs. Addressing STI, HIV, and pregnancy risk is important for both sexually active adolescents and those adolescents considering becoming sexually active. At a minimum, health providers should conduct a routine risk assessment during initial visits and on an annual basis. It is important to recognize that programs unable to meet this full definition of integration can still provide valuable services to their adolescent clients. For example, an agency could provide health education referrals to other viable community resources and/or positive reinforcement for the young person's efforts to adopt health protective behaviors.

While not every program has the capacity or intent to provide direct clinical services in all three areas, maintaining strong referral links with easily accessible programs in the community is an important priority for clinical and non-clinical programs alike.

### **What do we mean by Community?**

The use of the term community in this Guidebook is quite flexible. In the community-wide assessment conducted as a case study for this project, we designated community by geography and government boundaries. Yet during the assessment we found that the providers themselves comprise a different type of community, one defined by shared interests and goals. In other instances, we use the word community to refer to the people that programs serve, or the public as

distinguished from providers of service. For the purposes of conducting a needs and assets assessment of your community, the boundaries of the community should be defined in a way that best matches your assessment goals.

### **How does Integrated Service Delivery Affect Access to Care?**

The multiple barriers that adolescents face in accessing sexual and reproductive health services, especially clinical services, include:

- A lack of familiarity with the health care system and availability of services;
- Concerns regarding payment for services;
- Transportation difficulties;
- Not finding the time to come in for appointments; and
- Fear that confidential information will be disclosed to family or friends.

Strategies that make services convenient and non-threatening for adolescent clients are proactive about addressing multiple risk behaviors during the provider-client interaction, maximize the opportunities to provide preventive services, and reinforce messages regarding consistent use of condoms, safer sex, and other methods of contraception.

Opportunities to provide sexual and reproductive health services are often missed even with those adolescents who access some type of health services. One recent assessment of chlamydia screening coverage found that of 50,000 adolescents aged 15-19 who accessed care at a large multi-state managed care system in 1998/99, only 14.6% were screened. For this reason, merely making a wide array of health services available is not sufficient. Programs need protocols that integrate services, triggering routine services such as sexual history taking, STI screening and education, referrals and/or the provision of contraceptive methods, including condoms, for adolescent clients and their partners. Providers also need to provide adequate and timely training regarding implementing clinical guidelines and protocols.

From a health education perspective, integrated sexual and reproductive health messages make sense because the same prevention messages are often applicable to reducing STI, HIV, and unplanned pregnancy risk. Important components of integrated prevention messages include:

- Using condoms consistently and correctly;
- Negotiating safe sex practices and birth control with partners;
- Communicating openly with sexual partners about past sexual history and STI risk;
- Avoiding alcohol or substance use that increases risk of unprotected sexual behavior;
- Disengaging from violence-prone relationships;
- Developing self-esteem and emotional stability; and
- Making regular health care visits for STI screening and family planning services.

### **What is the Relationship Between Teen-Friendliness and Integration?**

While service integration can create a more teen-friendly environment by making multiple services easier to obtain and potentially avoiding the duplication of risk assessments and sexual history taking, there are many other ways a program can be teen-friendly. These include:

- Accessible service hours and locations;

Low or no cost services;  
Staff whom adolescents like and trust;  
Mechanisms to assure the confidentiality of adolescent clients;  
Clinical procedures that are non-invasive (e.g. urine testing for gonorrhea and chlamydia);  
Community outreach and services provided in multiple community settings; and  
Engaging teen involvement in program planning and/or service delivery.

Because integration does not encompass all aspects of teen-friendliness and vice versa, an assessment of each service delivery goal is necessary. However, one assessment can explore both teen friendliness and integration of services.

The implementation of teen-friendliness measures often require financial resources and/or staff time. Integrated services may require additional training for providers and/or the cost of providing additional screening and follow-up services for a new area of service. Balancing the allocation of resources to achieve both integration and teen friendliness goals is another reason to do a joint needs and assets assessment.

### **What is the Role of Integration and Teen Friendliness for Non-Clinical Programs?**

While this Guidebook is intended primarily for clinical programs, we recognize the important role non-clinic based sexual and reproductive health education programs<sup>4</sup> play in improving adolescent health outcomes. These roles include:

Focusing on primary prevention, including helping teens make decisions regarding both delaying having sex and avoiding pregnancy and sexually transmitted infections through health promotion, communication skills, and building self-esteem;  
Providing teens with the skills and information to take care of their health and utilize necessary clinical services;  
Encouraging youth to educate their peers about their risks and adopt positive health behaviors; and  
Addressing adolescents' concerns holistically by integrating sexual health with mental health, substance use, violence prevention, academic achievement, and familial stability whenever possible.

Many non-clinical programs are already highly integrated in terms of the health promotion messages they discuss with their adolescent clients. Throughout the country, program staff members are putting greater efforts in improving the teen friendliness of their services. Thus, while the integration assessment tools in this Guidebook are tailored to clinical programs, the teen friendliness inventory applies equally well to clinical and non-clinical programs and can be used for individual self-assessment by non-clinical programs.

It is important to include the perspectives of non-clinical adolescent service providers as they may offer important insights from working with a different population of adolescents than those found in clinical settings. Being sure to capture aspects of these relationships will make the needs and assets assessment on a community-level more useful, and could trigger ideas for improved coordination of services for a community's adolescents.



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<sup>4</sup> By using the term non-clinic based programs, we distinguish those programs that only offer health education in a variety of community settings from clinical programs that offer health education and counseling as part of their menu of services.

In terms of a community-wide assessment, non-clinical programs are an important resource to consider, because they can contribute by reinforcing prevention messages, referring adolescents to clinical services and when possible, following up on referrals to assure that adolescents have successfully sought needed care.

## Planning a Program Assessment

### What Does a Program Assessment Involve?

A program assessment is a systematic way to take stock of the current state of service delivery. Assessment tools, such as those offered in this Guidebook, assist programs in conducting a comprehensive review. These assessment tools recognize that every program operates under a different set of constraints. The goal is to identify program strengths, new needs, and areas for improvement. While your program may have previously conducted an assessment, the purpose of the tools included in this guide are to examine all of the important aspects of adolescent sexual behavior, pregnancy, STI and HIV/AIDS prevention, as well as the friendliness of services for teens.

Assessment data is gathered from administrators, direct service providers, and adolescent clients through interviews about service experience and written surveys about a program's operational structure (e.g., service hours, number of staff, volume of clients, etc.). Additional data on process indicators (e.g., the profile of services being provided to adolescents, how many are screened, etc.) and health outcomes (e.g., how many teens screened are found to have a positive diagnosis) may also be included. Findings are summarized and shared with participants and decision-makers to discuss the data and plan steps to improve services, for example, working to close important service gaps.

Future assessments can be planned to evaluate progress made and/or to identify new service delivery issues that need to be addressed.

### How Can a Program Assessment be Used?

- To identify programmatic strengths and weaknesses related to integration and teen friendliness;
- To plan attainable next steps to increase integration and/or teen-friendliness aimed at improving services for adolescents;
- To provide a community-wide picture of how adolescent sexual and reproductive health needs are being met;
- To show how well individual programs complement one another in providing a diverse array of services to a community;
- To make service providers in the same community aware of one another's activities, which can lead to greater networking, collaboration, and coordination of services;
- To better link community educational and clinical programs;

- To help plan collaborative efforts to improve service delivery, e.g., designing educational materials or launching a media campaign;
- To highlight strong programs within a community that others can learn from and adopt best practices; and
- To identify characteristics of programs that can facilitate integration and increase teen-friendliness of services.

## **Creating a Plan**

Before beginning a program assessment, either on an individual program or community-wide level, it is helpful to develop a project plan that includes a clear statement of goals, project scope, expected outcomes, available resources, and time frames. There are many important issues to examine in adolescent health service delivery. A focused, well-planned assessment will result in the most useful tool for planning action steps. For example, a program may choose to conduct an assessment when they review the epidemiology of county birth rates, as well as the incidence of chlamydia in their community, or they may choose to conduct an assessment as a baseline before they initiate a new program intervention. Whatever the motivation, it is important to conduct an assessment in a practical, and thorough manner.

The following outline can help organize your program assessment from the beginning:

### ***1. Clarify the goal of the program assessment***

Is the goal of your assessment to inform programmatic changes? To get a snapshot of adolescent services in the community? To improve collaboration among local service providers?

Use your goals to shape guiding questions and to help create clear and concrete objectives.

Use the questions to decide the scope of the assessment. In this guide, we use a series of modules to help answer a variety of issues. You may wish to review the modules (see Appendix I) to decide what will be the focus of your assessment.

In looking at the additional survey modules, evaluate the usefulness of each item by whether or not it contributes to answering the primary questions that you outlined as the assessment goals. Furthermore, if there are issues of concern not covered in these tools, we encourage you to develop your own.

### ***2. Determine the scope of the project***

Is this an assessment of programs for a specific group of adolescents? Is inclusion limited by the providers in a specific neighborhood or community? Which individuals are important to interview or survey?

Whether you conduct an individual program or a community-wide assessment, it is best to collect data from a variety of sources. People at different levels of an

organization have different and important perspectives (e.g., program coordinators, facility managers, health educators, and clinical providers). Of particular importance is obtaining input from adolescent clients. Very little data exists on what matters to adolescents when deciding whether to access services and what they prefer in terms of the array of health care venues available to them. Regular feedback on clients' perspectives and service satisfaction is an important part of creating teen-friendly services.

Decide whom you want to hear from: administrators, clinicians, health educators, adolescents, parents, and/or other community stakeholders, such as teachers or members of the faith community?

What types of programs will be included in the assessment? Clinical? School-based? Those that are funded through the Health Department? Those that target a specific population of adolescents?



When doing a community-wide assessment, it is important to get a full range of perspectives and program types. Ideally, this means recruiting several sites falling under each type of program, for example, health departments, family planning programs, STI clinics and designated HIV programs.

Define the boundaries of the community according to the most appropriate distribution: geographic boundary such as zip codes, programs serving a specific population, and/or members of a pre-existing consortium or coalition of service providers.

### ***3. Specify the product***

What are the expected products and who is the audience for the results of the assessment? Consider presenting your results in a variety of formats to highlight different findings that will most resonate with different groups. A final report for sharing with staff, policy makers, funders, and/or community members could be summarized in different fact sheets to reflect the interests of these groups. For example, funders and policymakers may be especially interested in seeing the cost saving implications while staff may be interested in learning what program models exist that they can replicate. In contrast, community members may want to know about services available. You may also plan a meeting to discuss the current state of service provision and ways to improve services. A listing of adolescent service providers and services offered or a brochure for potential clients as part of community-outreach strategies may also be a useful outcome.

### ***4. Assess your resources***

What types and how many people are available to work on this project? Is a project coordinator familiar with the community's programs? Interviewers who are experienced with interviewing or working with youth? An analyst that can manage and organize the data? Are people available on a full-time or part time basis? How flexible are staff's schedules for making appointments with providers and interviewing clients on site?

Having an independent, impartial project staff to conduct the assessment can  
**Hiring Independent Project Staff**

greatly improve the quality of the findings. A neutral interviewer can encourage more candid responses, resulting in a more objective assessment.

It is important to create an environment in which staff and clients feel comfortable expressing their opinion without fear of being penalized at a later time. With an independent data collector, the likelihood of protecting the confidentiality of participants may also be improved.

If you are unable to have an external assessment, an advantage of having a dedicated staff person on the project is the availability of someone to keep the project on track with respect to a planned time frame. These staff can conduct semi-structured interviews that allow people to share their opinions, relate their experiences anecdotally, and provide a richness of detail to inform the assessment. Whether you have an internal or external assessment team, it is likely that they will need orientation to the scope of the project, trainings needed, and designated time to conduct their efforts.

### ***5. Set the time frames***

What are the time frames for conducting the project? Is there an external time frame for completing the project (e.g., funding cycle, progress report, upcoming meeting, etc.)? Are there internal expectations for beginning and ending the project?

Timelines should take into consideration transportation to remote sites, the potential need for multiple visits per site, and accommodating the seasonal fluctuation of client volume that programs serving adolescents must contend with (e.g., school holidays, larger numbers of new clients at the beginning of each semester).

### ***6. Choosing the kind of data to collect***

One of the important decisions about conducting a more in-depth individual or community wide assessment is whether to use interviews or written surveys or both. In this section, we describe advantages and disadvantages of conducting interviews or written surveys.

#### **Conducting Interviews**

Are best for gaining a deeper understanding of what people think

Can be time intensive for project staff

Requires participant confidentiality

May require the taping and transcribing of interviews and/or the design of a well laid out data collection form to help interviewers take notes.

#### **Written Surveys**

Are good for collecting information that has discrete yes/no or categorical type answers

Should be clear, easy to answer, and not take too much time to complete

Can be administered to many people at once, or given to people to fill-out at a time that is convenient for them  
Can be conducted anonymously, if a few general descriptors of the respondents are collected to aid in interpreting the results (e.g. the job position, or how long the provider has been working in the program).

### **Ensuring Participants' Confidentiality**

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Asking participants to provide candid opinions about services they provide or utilize requires a method of collecting their responses in a confidential manner. This is both for the protection of the respondents and to ensure a less biased assessment result. Here are a few ways to protect the confidentiality of assessment participants:

If in-house staff are used to conduct the assessment, use a survey method so that participants can provide their responses anonymously (e.g., through self-administered surveys rather than interviews, placing their completed written surveys into an anonymous box or envelopes).

If names are collected, they should not be linked to specific comments or opinions in the write-up of the data. Review the process by which responses will be kept confidential with the participants.

Remind participants that their responses are voluntary and that there is no penalty for not responding to any specific question.

Conduct all surveys under conditions where participants do feel they have privacy (e.g., with no one else around).

## **7. Selecting the data collection instruments**

This Guidebook contains assessment tools for determining where in the spectra of integration and teen-friendliness a program stands. Complete instructions for using these instruments are provided in these sections.

In addition, this Guidebook includes several other modules in the Appendix to aid providers in collecting data on other important issues of sexual and reproductive health service delivery for adolescents.

### **Additional Survey Modules:**

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Provider Modules – For Interviews or Written Surveys  
Provider Demographics  
Program Mission, Strengths and Innovations  
Barriers, Solutions and Facilitators  
Vision for an Adolescent Sexual and Reproductive Health System  
Involvement of Teens and Parents in Program Planning

Adolescent Modules – For Interviews or Written Surveys  
Provider Demographics  
Accessing Services/Warm-up Questions  
Client's Opinions About the Program  
General Barriers to Care and Teen friendliness Issues  
Missed Opportunities & Knowledge of Services  
Who Teens Can Talk to About Sex  
Summary and Demographics

Structural Survey – For Written Surveys  
Client Demographics

Scope and Availability of Clinical Services  
Scope and Availability of Non-Clinical Services  
Funding Sources for Clinical Services  
Practice Guidelines and Policies  
Staffing Clinical Programs  
Staffing Non-Clinical Programs

## Overview – Six Steps to an Individual Program Self-Assessment

Decide on whether to hire an independent project staff person to conduct the assessment or to use in-house staff resources.

Choose the appropriate survey instruments and collect the necessary data.

Use the Integration Rating System to determine your program's level of integration (see page 18).

Complete the teen friendliness inventory based on the data collected (see page 24).

Analyze the data and discuss next steps for your program to achieve higher levels of integration and/or teen friendliness with program staff.

Follow-up service delivery changes by conducting periodic re-assessment, client satisfaction surveys, and/or monitoring health outcomes, such as positive STI or pregnancy tests, or positive HIV tests.



## Organizing a Community-wide Assessment

A community-wide assessment requires more time and planning than an individual agency assessment, but can provide valuable information and suggest action steps to improve services for adolescents on a more systemic basis across a community:

Foster collaboration between agencies;  
Create stronger referral networks; and  
Identify gaps in service across the community.

There are two primary approaches for conducting a community-wide assessment:

- 1 Having an independent project team that schedules site visits to programs, administers surveys and interviews, summarizes findings, and facilitates next steps; or
- 2 Organizing a collaborative effort in which an existing or newly formed coalition of programs conducts separate self-assessments using the same instruments during a specified time period, and then shares these results with one another and discusses next steps together.

A community's choice of which approach to use (or a potential hybrid model) depends partly on the resources available and partly on the time frames needed to complete the project.

## Independent Project Team Approach

An independent project team approach requires a staff of one or more people, dedicated to coordinating and carrying-out the project. Team tasks will include

readying data collection instruments to scheduling provider time for interviews. Because staff are available to do most of the work, program administrators may be more willing to participate. Project staff should assure the program's interviewers that they can feel comfortable giving honest feedback about the program's strengths and weaknesses.

### **Summary – Eight Steps for a Project Team or a Self-Assessment Approach to a Community-wide Program Assessment**

The community-wide self-assessment approach has the advantage of spreading the work and responsibility for completing the assessment evenly across the participating agencies. Programs may also feel more comfortable about self-assessment than allowing an external reviewer to examine their program. The disadvantages of this approach include potential inconsistencies in using the self-assessment tools, and the lack of confidentiality in interview situations for providers and clients to express their opinions about program strengths and weaknesses.

To use the self-assessment method, it is important that the coalition have a strong system for coordinating programs or a lead agency to spearhead the effort, with some designated staff or staff time for the project. A mechanism for ensuring confidentiality of respondents is also advised. Whichever format you choose, convene participating agencies to plan the assessment and reach consensus on the goals, desired end-products, time frames, instruments to use in the assessment, and how data results will be reported (e.g., what information will be reported devoid of specific agency names.)

#### **Specific Steps:**

- Schedule interviews with program administrators and make arrangements for administering surveys to providers and adolescents.
- Have each program follow steps for conducting a program self-assessment by completing a standard set of instruments.
- Develop a reminder system to keep participating programs on track.
- Conduct interviews and administer surveys.
- Aggregate comments, tabulate results and distribute program-specific data to participants for review and comment.
- Write up a report of findings that maintains the confidentiality of programs and providers and organize a meeting with participants to discuss the results as a group.
- Develop a community-wide report that maintains confidentiality of individual agencies but also makes information available to different audiences, such as program managers and policy makers.
- Organize a meeting to plan next steps and a process for community-wide service delivery improvements.

Whichever approach is chosen, individual programs should be encouraged to review the data collected from their own program and identify strengths and areas for improvement. In the following Chapters, we present specific details to help you create integrated and teen-friendly services.

## Integration: Determining a Program's Rating and Planning Next Steps

### **Clinical Programs**

The primary goal of integration is to improve clinical service delivery for adolescents with multiple sexual and reproductive health issues. The key points on service delivery integration are:

A sexual and reproductive health risk assessment as a routine part of adolescent health visits;

Clinical services and counseling in STI, HIV, and family planning areas are offered or recommended to sexually active adolescents or adolescents planning to become sexually active;

When an adolescent seeks services in one area of sexual and reproductive health, services in the other two areas are also offered;

If the adolescent chooses to access services in all three areas at once, they are available during a single visit to a health care facility and completed without a long wait;

If services cannot be provided on-site, adolescent clients are referred to an appropriate agency offering these services; and

Referral linkages and follow-up appointments for services not offered on site or during other hours are regularly confirmed and followed through.

Reflecting these priorities, the continuum we describe below takes the client's perspective and considers the degree of service integration, resulting in a score ranging from 1 (single focus) to 6 (full integration).

### ***Examples of Programs in each Sexual and Reproductive Health Integration Category***

**1. Health Education & Counseling**—consistent, coordinated messages about multiple risks

To determine an individual program's level of service delivery integration, review the following possible scores.

### **Integration Score = 1**

An anonymous HIV testing center without links to STI or family planning services

A family planning clinic serving clients of all ages that provides pregnancy testing and hormonal methods of contraception, but does not offer STI or HIV screening.

A case-management program for new teenage mothers. Family planning services and STI screening are

### **Integration Score = 2**

provided at regular health-check-ups. No referral links are available for HIV counseling and testing.

### **Integration Score = 3**

A school clinic offering pregnancy testing and family planning methods on campus, but refers patients to county health department clinics for all STI and HIV services.

A clinician trained in adolescent medicine working at an in-patient adolescent substance use treatment facility offers all adolescents HIV testing, but limited time allows only a portion of all adolescents to be screened by the clinician for STIs and pregnancy.

A teen family planning clinic offers routine STI screening to adolescents upon initial visit. HIV counseling & testing is available at affiliated clinic.

### **Integration Score = 4**

A Juvenile Hall offering STI and family planning screening upon intake, but has HIV counseling and testing available on site once a week.

A community teen clinic screens all adolescents for STI, HIV, and pregnancy risk at their initial visit. However, the HIV counselor is only available on Wednesday mornings and clients are rescheduled for appointments to undergo counseling and testing. The system of internal referrals is carefully monitored to assure client follow-through.

A large managed care teen clinic has established protocols for conducting a sexual history and risk assessment on all sexually active adolescents to assess their need for STI, HIV, and family planning services. As part of the same visit. For teens who are sexually active or planning to be, all services are provided on site and are

### **Integration Score = 6**

available during the same visit.

## **Non-clinical Programs**

Integration issues for clinical and non-clinical program can be quite different. Non-clinical programs addressing sexual and reproductive health issues for adolescents include various combinations of health education and awareness, skill building, and other aspects of youth development.

The concept of integration can refer to multiple dimensions of service provision in this context:

#### **CONTENT:**

Are adolescents' risks for STI, HIV, and unplanned pregnancy addressed by the program? (Are all three risk topics raised? Are adolescents given information about how to protect themselves?)

**RESOURCES:**

Are non-clinical programs linked to programs offering clinical services that adolescent clients may need?

**YOUTH PERSPECTIVE:**

Is sexual and reproductive health put in the context of other issues that adolescents are concerned about or interested in? (Is there a holistic approach to improving the health and well-being of adolescents? Is sexual and reproductive health made relevant to adolescents' attitudes and concerns about romantic relationships, violence, family, academics, long-term goals?)

While we have not developed a non-clinical program's counterpart to the clinic integration score flow chart, program assessments, including non-clinical programs, can incorporate an assessment of these levels of integration and use these areas to guide the development of next steps for program improvement.

Once you know where you are in the spectrum of integration, you can begin to decide what is the next achievable level of integration feasible for your program. Consider that many of the strategies to increase integration are relatively low cost and doable.

### **Planning Next Steps for Achieving Higher Levels of Integration**

**No Score:**

If the program you are assessing did not have a score because a risk-assessment for all three areas of sexual and reproductive health is not conducted routinely with adolescent clients, this is a critical first area to address. See the section on page 28 for a guide to implementing routine risk assessments. We then encourage you to return to this assessment process.

**Programs Scoring 4 or less:**

One of the most important next steps for these programs is to ensure that referral links to services not provided on-site are in place and effective for helping adolescents to receive a full complement of sexual and reproductive health services off-site. Ideas for how to initiate referral links and ensuring the quality of linkages already in place are described on page 29.

Once good referral linkages are in place, it is a good idea to evaluate the possibility of adding to the sexual and reproductive health services offered. For some programs adding a new service area used with adolescent clients and developing referral or rescheduling mechanisms is easier than trying to have all services available on site during all service hours.

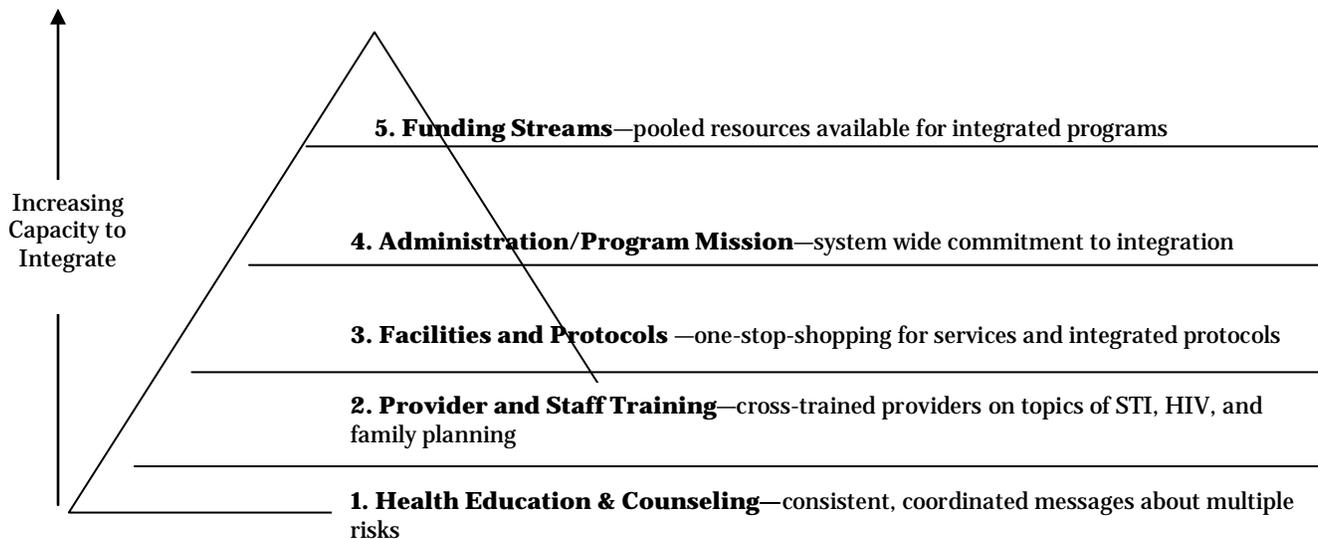
Determining what is best for your program requires a look at how different levels of an organization are involved in the implementation of integration. If you are considering expanding or enhancing your current services—from adding routine client risk assessments to implementing full integration—you should consider these dimensions. Understanding how these organizational levels impact service delivery can assist in more strategic planning.

## **Integration as a Multi-level Effort**

The ability to achieve integration varies at each level. In this section, a framework for considering issues of integration is presented and each dimension is discussed in detail, below.

### ***Dimensions of Sexual and Reproductive Health Service Integration***

Dimensions of program integration are reflected in Figure 1, including whether education and counseling services provide integrated messages, availability of staff training, to consideration of how different funding streams can be used.



### ***1. Health Education and Counseling***

Within the clinical setting, addressing the multiple health risks associated with sexual risk-taking in health education messages delivered to adolescent clients is a basic, minimally resource intensive, means of integrating preventive health services. At the beginning of health care visits, providers are able to offer individually tailored risk-reduction health messages and reinforce positive health behaviors adopted by clients through routine use of self or provider administered risk assessment surveys.

Using these risk assessment tools to their full advantage may entail additional cross-training for providers. Examples of some instruments currently used by different clinics and information on other sources can be found in the Resource section of this Guidebook.

## ***2. Provider and Staff Training***

Every staff person having contact with adolescent clients should be provided with training opportunities - from front desk clerks to health educators, nurses, nurse practitioners, and physicians. Investing in cross-training of providers in each of the areas of family planning, STIs, and HIV, updating their knowledge of new treatment guidelines, teaching them new strategies for working with adolescents, and/or helping them keep abreast of changes in legislation can greatly improve the quality of integrated service delivery.

Even if training cannot be arranged program-wide, it is valuable to support individual providers who pursue additional training (e.g. continuing education, annual conferences or meetings, etc.) and can bring new ideas and share best practices with other providers in the program.

See Resources on page 52 for training options.

## ***3. Facilities and Protocols***

Implementing integrated service delivery in a consistent manner requires the adoption of protocols that specify how adolescent clients are to receive integrated sexual and reproductive health services. Developing and adopting these program changes requires the support of the administration, providers, and support staff. Staff support may increase if the new protocols are consistent with national guidelines, and if the evidence from other programs using similar protocols demonstrate positive results. For example, by attracting or retaining more adolescent clients, increasing client satisfaction, and/or improving health indicators (e.g., increased chlamydia screening coverage, reduced teen births, etc.) providers may feel more positive about implementing new guidelines and working towards continuously improving their services.

New protocols are more easily adopted when the program infrastructure supports the new policies. For example:

- Designing a risk assessment tool for clients to complete at the beginning of their visit assists providers in conducting a comprehensive review of a client's risk profile;
- Programs may need to adopt new scheduling patterns for exam rooms or the coordination of providers' schedules in order to offer a full array of services to adolescent clients; and
- Integrated medical records that capture family planning services, STI services, and HIV counseling and testing

## ***4. Administration/Program Mission***

in a single chart also facilitate integrated care from providers.

Programs that adopt integration or one-stop-shopping for adolescent clients as a part of their mission statement make seamless service delivery a priority. Administrative buy-in on integrated service delivery reinforces policies and protocols that support integration, facilitates program evaluation and leverages resources to implement systemic solutions to integrating services.

## **5. Funding Streams**

One of the biggest barriers in offering integrated services is the separate funding streams that reimburse programs for specific areas of sexual and reproductive health clinical services. For example, money earmarked to support HIV prevention programs may not be awarded to groups whose programs address adolescent sexual health in general, devoting as much time to responding to family planning and STI risks as to issues specific to HIV risk. To obtain grants, administrators must be able to demonstrate that the goals of funders are met in an integrated system. Identifying and pursuing funding streams that encourage integrated service delivery is an important task for both program administrators and policy makers.

When funding sources supporting integrated service delivery are not available, administrators play an important role in blending separate funding streams in a way that appears seamless to the adolescent client (e.g., streamlining the paperwork filled out by clients to obtain reimbursement for services.)

## **Considering Your Next Steps**

Considering how these levels of integration apply to your program when reviewing the results of your integration rating will help to pinpoint the areas of service delivery that are most feasible for your program. Identifying priority areas for implementing service delivery changes also needs to consider the community your program serves. This type of assessment entails examination of the health outcome data that may be available for your area (e.g., incidence of STIs, teenage births, HIV/AIDS among teens and young adults) and an inventory of the types of other programs offering sexual and reproductive health services to adolescents in your community. For more help in incorporating outcome data into your planning process, see the section on Linking Health Outcomes to Service Delivery Changes on page 41.

## **Assessing the Array of Integrated Services on a Community-wide Basis**

After gathering the data to complete the needs assessment for each program, there are several ways to assess the status of integrated service delivery on a community-wide basis. Arranging the data on multiple programs into grids or figures can help to identify patterns in service delivery across the community. Here are just a few ideas to get you started:

***Step 1. Examine the variety of programs in your assessment using the venue type-module and the funding-type module below.***

### **A) Integration by Venue Type:**

Fill in the name of each program in your assessment under the appropriate venue category. Add the integration score, including whether STI, HIV, and/or Family

Planning services are provided (for those programs scoring less than 4). If the program provides teen-specific services, put an “X” in the far right column.

<b>WORKSHEET 1: Examples of Integration and Referral Patterns by Venue Type</b>			
<b>Program Name</b>	<b>Integration Score and On-site Services</b>	<b>Type of Referrals Provided</b>	<b>Teen Specific?</b>
<b>Community Based Clinics</b>			
<i>Example:</i> Rosewood Community Clinic	Score 3, STI and Family Planning services on site. HIV	HIV	X
<b>School-Based Clinics</b>			
<i>Example:</i> Washington High Clinic	Score 2, Family Planning services on site. STI and HIV	STI and HIV	X
<b>Primary Care Settings</b>			
<i>Example:</i> Tree of Life	Score 1, No Family Planning, STI, and HIV services on site,	FP, HIV and STI	X
<b>In-patient/Institutional Settings</b>			
<b>Family Planning Clinics</b>			
<i>Example:</i> New Generation Clinic	Score 4, All STI, HIV and teen pregnancy prevention services are offered on site.		X
<b>Perinatal Clinics</b>			

<b>WORKSHEET 1: Examples of Integration and Referral Patterns by Venue Type</b>			
<b>Program Name</b>	<b>Integration Score and On-site Services</b>	<b>Type of Referrals Provided</b>	<b>Teen Specific?</b>
<b>HIV Counseling and Testing Clinics</b>			
<b>STD Clinics</b>			
<b>TOTAL SCORE</b>	<b>10</b>		<b>4</b>

**B) Integration by Funding Type**

If you are interested in assessing the different funding streams available to support services, you can review your community through this dimension. Fill in the name of each program in your assessment under the appropriate funding category. Add the integration score, including whether STI, HIV, and/or Family Planning services are provided (for those programs scoring less than 4). If the program provides teen specific services, put an “X” in the far right column.

<b>WORKSHEET 2: Integration and Referral Patterns by Funding Type</b>			
<b>Program Name</b>	<b>Integration Score and On-site Services</b>	<b>Type of Referrals Provided</b>	<b>Teen Specific?</b>
<b>Publicly Funded</b>			
<b>Private Health Plan</b>			
<b>Community Based Organization/Grant Funded</b>			

<b>WORKSHEET 2: Integration and Referral Patterns by Funding Type</b>			
<b>Program Name</b>	<b>Integration Score and On-site Services</b>	<b>Type of Referrals Provided</b>	<b>Teen Specific?</b>
<b>TOTAL SCORE</b>			

**Questions to ask:**

Is there a pattern to the integration scores that is related to the type of venue or funding?

Are there a variety of programs accessible to adolescents? For adolescents in high-risk groups, or who face barriers to care (e.g., low social economic status, youth of color, homeless youth, gay, lesbian or bi-sexual youth), are there services that make special efforts to recruit these groups or are they readily accessible to adolescents?

For agencies scoring fewer points, is there an adequate referral and follow-up system in place to assure that teens get the array of services they need?

List the programs in your assessment by order of their integration score.

**Step 2. Review the distribution of programs by integration score.**

**Questions to ask:**

Do most programs have high or low scores?

Is there a pattern to the services offered by programs that score 4 or less? (e.g., all offer STI and family planning, but not HIV services?)

What referral relationships exist by type of agency?

**Step 3. Assess the service coverage for adolescents across the community.**

How does the distribution compare to what adolescents say about wanting one-stop-shopping, specialty service settings, or both?

Get a map of your community. If available, use a map that is shaded according to the number of adolescents and the STI rate and birth rate for adolescents by zip code or census track or other geographic area.

Mark the location of each program in your assessment, using a different color or marker for programs with different integration scores.

Are there areas in the community that have fewer service programs?

**Questions to ask:**

Are programs located in centralized, easily accessible areas? If not, what are transportation resources?

Do adolescent clients have a choice of different type of programs that are conveniently located to them?

If you are using a map showing population or health outcomes, does the distribution of services reflect the pattern of population density and/or health outcomes?

#### **Step 4. Determine the completeness and quality of referral networks**

Review type of referral systems that are in place.

Assess whether there is any information on the completeness of referral patterns.

Consider ways that service integration could occur on site.

Consider ways that referrals can be improved.

#### **Questions to ask:**

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Are there programs that could serve as potential referral links?

Are most of the referrals between partially integrated programs, trading referral links, or between partially and fully integrated programs?

#### **Follow-up:**

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An important aspect of referral network assessment is determining what proportion of referrals made result in actual visits by adolescent clients. A good follow-up activity is to track the referrals made by each program in the assessment to determine the proportion that are successful (i.e., result in an actual visit).

#### **Summary**

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The worksheets that are most helpful depend on the data that you have collected. Use your creativity to develop data presentations that are most relevant to your community and the questions you are trying to address through this program assessment.

#### **Establishing Routine Risk Assessment**

National guidelines<sup>5</sup> for adolescent preventive health services agree on the importance of conducting a routine risk assessment for adolescents seeking clinical services. These risk assessments should be conducted on at least an

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<sup>5</sup> These include the national guidelines from: (1) National Center for Education in Maternal and Child Bright Futures for Health Supervision of Infants, Children and Adolescents, (2) the U.S. Preventive Services Taskforce's Guide to Clinical Preventive Services, and (3) the American Medical Association's Guidelines for Adolescent Preventive Services. See the Resources section of the Appendices for more information.

annual basis with adolescent clients and cover a wide range of health behaviors including sexual behavior, violence, substance use (including alcohol and tobacco), seat belt use, bicycle helmet use, academic performance, and mental health (American Medical Association, 1997). For those adolescents who infrequently access care, every visit with a health care provider, whether it be for sick care or for a sports physical, is an opportunity to conduct a risk assessment.

There are several approaches for conducting risk assessments:

Clients can be given risk assessment surveys to complete while they wait for their appointments with providers. Providers may prefer to review preventive health behaviors with clients at the beginning of the visit. Clients may be seen by a health educator or public health nurse to discuss preventive health before or after being seen by a provider.

To ensure appropriate risk assessments for adolescent clients at your program, you need to:

Develop or adopt a tool for ensuring that a comprehensive risk assessment is administered, e.g., a written survey instrument for clients or a checklist for health professionals.  
Have an explicit protocol in place for routinely administering risk assessments to adolescent clients.  
Keep a record that the risk assessment was conducted and that providers discussed findings with clients as part of the client's medical record for future reference. Review confidentiality provisions in your state to establish how confidential information will be maintained as part of the medical chart.

Ideally, providers should be given a separate tool to help document their interactions with clients regarding the risk assessment, while also assuring clients of the confidentiality of the information:

To ensure a service provider reviews the risk assessment with the client and reinforces positive behaviors already adopted, as well as address areas to reduce risks.  
To train providers to be knowledgeable about the referral processes that are available for services the adolescent client may need, but that are not available on-site.  
To train providers to be sensitive and non-judgmental interviewers and users of risk information.

For some examples of risk assessment tools, see pages 61-66 in the Appendix.

### **Ensuring Strong Referral Linkages**

Not all programs can or plan to offer a full array of clinical sexual and reproductive health services. However all programs need to provide referrals to service agencies that can meet the sexual and reproductive health needs of adolescent clients or complement your own current services. The following section outlines features of strong referral linkages between programs serving adolescent clients.

The qualities of an appropriate referral agency include:

High quality clinical services;  
A facility that is conveniently located for the adolescent client;  
Services that are available at low or no cost;  
Sensitive services provided to adolescents by trained non-judgmental staff; and  
Privacy rights of adolescents are respected and protected.

When developing referral linkages with another facility, some simple steps can improve the success of a referral completion (i.e., number of clients who follow-through with the referral):

- ★ Meet with the program director or clinic manager to set up the referral process.
- ★ Discuss the types and anticipated numbers of clients that will be referred.
- ★ If possible, set up a system by which your program's staff can assist adolescents in making appointments with the referral agency or otherwise notify the referral agency that a client should be expected to set up an appointment.

Implement a notification system for letting referring programs know that their clients have been seen and have received services (e.g., through letters, emails or phone calls).

Provide the clients with information about the program to which they are being referred. Have a supply of program brochures or one-page information sheets that give the program address and directions for getting there, hours services are available, and contact information for making or changing an appointment.

If available, provide the client with the name of the provider they will be seeing.

Give the client the option of having confidential copies of their medical record sent to the other facility at no charge and vice versa, to ensure greater continuity of service.

Evaluate referral linkages periodically. Set-up a system to determine how many of the referrals made result in a visit to the referral agency.

Survey adolescent clients about how the referral process can be made easier for them and other teenagers and how satisfied clients were with the services they received.

Remember, these steps must abide by HIPAA requirements (<http://www.hhs.gov/ocr/hipaa/>).

## Teen-friendliness: Taking Stock and Planning the Next Steps

Teen friendly services are critical for increasing adolescent access to sexual and reproductive health care and improvement in adolescent health outcomes. Access refers to attracting clients to programs, to helping clients feel comfortable talking about sensitive issues with providers, fostering regular health care visits, and creating referral resources for other types of mental health and social services.

The following teen-friendliness inventory lists components that adolescents and providers in previous studies have identified as important to making a program welcoming and comfortable for adolescent clients. While the inventory components are based on the experience of clients and providers, it is still worthwhile to determine what teen-friendliness means for your particular population of adolescents.

Asking adolescents about how they would design a program, or what they like and don't like about current services is another way to address issues of teen friendliness. Some of these types of questions are included in the self-administered questionnaire for clients that is part of completing the teen-friendliness inventory (see Appendix B.).

Every program, both clinical and non-clinical, works within a specific set of resource constraints to support efforts to improve teen friendliness. The purpose of a program assessment on teen-friendliness is to identify program strengths and areas for improvement. Some improvements in teen friendliness are easier to adopt than others. Finding the right next steps for your program can only be determined by people familiar with your program. However, this Guidebook tries to provide ideas for improving each area of teen friendliness.

### **How to Complete the Teen Friendliness Inventory**

To assess the state of your program's teen friendliness rate use the Teen Friendliness Inventory (page 83 of Appendix). Check the appropriate column for each component, then total the scores as described by the instructions at the end of each section. You may find that some of these components do not apply to your program, given the types of teens you serve. For example, offering testing services

are not relevant to non-clinical health education programs, or being accessible by public transportation is not relevant for in-patient clinic services or juvenile hall programs. If this is the case for your program, simply check the “Does not Apply” box in the column.

For the most part, a program administrator can determine if the program meets a component. However, the last section requires gathering some opinions from a sample of providers and adolescents. The next section offers help on how to conduct these surveys.

**Tool X: Teen Friendliness Inventory**

<b>A. Structural Elements</b>	<b>Component Met</b>	<b>Component Unmet</b>	<b>Does not Apply</b>
1. Services are available to teens for free or at low cost.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Services are designed specifically for teen clients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Special service hours or all service hours are designated for teen clients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Evening and weekend service hours are available to teen clients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The program facility is easily accessible by public transportation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The program has implemented protocols to protect the confidentiality of teen clients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SUBTOTAL</b>			

<b>B. Teen Involvement</b>	<b>Component Met</b>	<b>Component Unmet</b>	<b>Does not Apply</b>
7. Teen clients have input in the design of services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Teen clients organize events or presentations for peers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. A holistic approach to teens is incorporated in all aspects of the program (so that psychosocial elements—mental health, self-esteem, exposure to violence, etc.—are included along with overall physical health).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. Provider Characteristics</b>			
10. Providers support the concept of integrated sexual and reproductive health services, including providing referrals to clients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Providers are trained to work with and establish rapport with teen clients, including use of client risk assessments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Providers give care in a non-judgmental and supportive manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Providers participate in continuing education opportunities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Provider demographics (e.g., gender, race-ethnicity) reflect those of the teen clients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>D. Services Offered</b>			
15. Outreach for teen clients is conducted in community settings (e.g. ,health fairs, mobile vans, neighborhood visits by outreach workers).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. STI testing services are available outside the program facility by program community outreach staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SUBTOTAL</b>			

<b>D. Services Offered (cont'd)</b>	<b>Component Met</b>	<b>Component Unmet</b>	<b>Does not Apply</b>
17. Urine-based chlamydia and gonorrhea tests are routinely used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E. Provider/Client Options*</b>			
18. A majority of teen clients would recommend this program to a friend.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Client-Provider relationship is seen as a strength by a majority of providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Client-Provider relationship is seen as a strength by a majority of teen clients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Protection of teen client confidentiality is seen as a strength by a majority of providers. **	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Protection of teen client confidentiality is seen as a strength by a majority of teen clients. **	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>TOTAL:</b>			

\*These components are evaluated based on interviews or surveys with providers and teen clients evaluating program services. See p. XX for more information on conducting surveys and what sample instruments are included in the Appendix

\*\*Confidentiality applies to both medical records and information disclosed during counseling sessions. Programs which only include a didactic approach should mark Does Not Apply.

### To calculate the Teen Friendliness rating:

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Subtract the total in *Does Not Apply* (Col 3.) from the number 22:

\_\_\_\_\_

Divide the total number of *Components Met* (Col 1.) by the number on the line above to get your Teen Friendliness Rating: \_\_\_\_\_

If a program has a total of 3 “Does Not Apply” responses, the available score would be 19. If the components net score was 10, then the available score is 10/19. The possible range of teen friendliness (if all components apply) is between 1 and 22, the higher scores indicate a higher degree of teen-friendliness.

### Gathering Provider and Client Options about Services

To complete Section E of the Teen Friendliness Inventory, it will be necessary to survey both providers and adolescent clients. This Guidebook contains survey modules that can be used as interview instruments or written surveys for both groups (see Appendix).

To meet the criteria of what constitutes Teen Friendliness, a majority of providers and clients surveyed will need to identify the strengths of a program as providing confidential services, establishing trust in the provider-client relationship, and identifying if clients would recommend the program to a friend.

### Surveying Providers

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For providers, a short module specifically designed for completing the teen friendliness inventory is provided in Appendix I. If more extensive surveying of providers is planned, the questions in this module can be appended to a larger instrument.

The number of providers surveyed depends on the size of the organization. If the organization is smaller than 10 service providers, it is reasonable to include all providers in the survey. If the organization is much larger than 10 and a longer survey instrument is being used, it may be necessary to administer the short-form of the survey to all providers, and select a smaller group for more in-depth interviews or questionnaires.

### Surveying Adolescent Clients

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For adolescents, a combination of adolescent modules: *1. Accessing Services/Warm-up Questions*, *2. Clients' Opinions About the Program*, *3. General Barriers to Care and Teen Friendliness Issues*, and *6. Summary and Demographics* (See Appendix) can be used to assess and gather clients' opinions about the program and provide other valuable information about clients' perceptions of teen friendliness.

Surveys can be administered to all adolescents coming to the program for services over a limited period of time, such as one week or one month depending on the flow of clients in the program. Programs that serve a consistent group of adolescents over a semester or a year, e.g., a peer-education program, should try to survey all their clients at least once, preferably at the beginning of their program participation to assess their needs, but later in the program to assess the ratings of program friendliness.

### **Planning Next Steps for Improving Teen-friendliness**

After completing the inventory of teen friendliness, review the sections that have the greatest number of unmet components. Determine where you can take steps toward greater teen friendliness. This section provides some specific ideas that may help you find concrete ways to meet these goals. We encourage you to consider what strategies work best in your own setting and community. Be sure to include young people in reviewing these strategies.

**1. Free or low-cost services** – Assuring that adolescents are not turned away due to income considerations may be the greatest problem. If your clinic is unable to provide free or low cost services, consider identifying a community source that does, for example, health departments. Even a co-payment may create significant barriers to adolescents.

Federal funding specifically for family planning services through Title X allow female adolescents to receive care regardless of insurance or ability to pay out of pocket. These funds support clinics that offer a comprehensive array of contraceptive choices, as well as offer a wide range of related health services including screening and treatment for STIs, testing for HIV, safer sex counseling, and pelvic exams.

In California, male and female adolescents are eligible for coverage of sexual and reproductive health services through the California State Department of Health Office of Family Planning's Family PACT program (Family Planning Access, Care and Treatment). To find out more about becoming a Family PACT provider see the Resources section of the Guidebook.

Special Medi-Cal (California's Medicaid Program) coverage, known as Medi-Cal Sensitive Services, exists for adolescents, even for those adolescents who may already be covered by medical insurance through their parents, but who need further assurance of confidential services.

**2. Evening and Weekend Hours** – Making services available at hours that work well for adolescent clients' schedules means considering offering services after school and on weekends.

Do a survey among clients to see which hours would be most convenient for them.

See if staff members are willing to stagger their schedules so that later service hours are available.

Collaborate with other nearby agencies trying to expand services by sharing facilities and support staff.

Begin offering expanded hours for services that are most in demand by adolescent clients.

Evaluate service utilization after a reasonable period of time. An important question to ask is whether the volume of clients served increases? (e.g. Are the clients coming during the new service hours, the same clients that used to come during regular hours? or is a new group of clients able to access services?)

**3. Accessibility by Public Transportation** - Even if moving facilities is not a practical solution, there are ways to make program facilities easier to reach.

Create fliers that show the most direct route to the program on buses or trains from popular locations, such as school or the mall. Include evening and weekend hour schedules, if services are offered during these times.

For routes that require multiple transfers, provide bus passes or otherwise subsidize fares.

**4. Protecting the Confidentiality of Adolescent Clients** – The importance of this component cannot be underestimated. Even if measures are in place to ensure client confidentiality, it is important that clients are aware of these policies and feel protected by these efforts.

- Make sure providers are aware of confidentiality laws and access to care laws for adolescents.
- Establish protocols and procedures for contacting clients when follow-up is necessary. For example, use beeper and cell phone numbers (including text messages), or use a person's name instead of the clinic name when calling the client's home.
- Have providers review the program's confidentiality policies with their patients. Be clear about the exceptions to these rules.
- Tell adolescent clients what will happen if their parents request access to their medical records or information from their providers.
- Notification regarding provision of care to managed care clients should *not* be mailed to clients' homes.
- Billing to parents should not reflect confidential services sought by adolescent clients.
- Review appropriate mechanisms for reporting test results without breaching client confidentiality.
- Conduct client-provider interactions in private rooms where others cannot overhear conversations.
- Train all clinic staff to handle medical records and confidential material.
- Evaluate these efforts by surveying clients' knowledge on program policies regarding confidentiality, as well as their ability to access confidential care in the community.

**5. Involving Teens in Designing Services** - There is no better way to develop teen friendly and responsive services than by involving teens in the process of designing services. There are both formal and informal ways of accomplishing this goal:

- Set-up a teen-advisory board to give input on program services, or include teen representatives on advisory boards with community members, teachers, and parents.
- Conduct anonymous client-satisfaction surveys that allow teenagers a way to provide timely feedback about services.
- When designing new services, conduct focus groups or client surveys about what adolescents would like to have available.
- Implement peer-education programs, where adolescents undergo training and then provide education or facilitate discussions with their peers. For more information on how to start a peer-education program, see the Resources section of the Appendix.

**6. Adopting a Holistic Approach to Adolescent Services** – One way to integrate and reinforce teenagers' responsible sexual and reproductive health behavior is to discuss these topics in the context of other life concerns they might have, including the following:

- Develop and integrate comprehensive adolescent risk assessment tools that include sexual behavior along with information on clients' substance use, mental health, family dynamics, etc.
- Collaborate with other organizations that focus on youth development and have an interest in linking clients to health services.
- Conduct health education sessions as part of sexual and reproductive health programs focusing on other aspects of adolescent well-being, for example, negotiation skills in relationships, stress reduction, links between substance use and abuse, and sexual and reproductive health risks.

**7. Improving Provider Rapport with Clients** – Adolescent clients in clinical and non-clinical settings need to feel comfortable to talk openly with their providers in order to benefit most from available services. Staff members need to be able to relate to clients, be trustworthy, nonjudgmental, and knowledgeable about the information.

- Hire and train peer health educators when possible. Value youth staff by paying them fair wages and providing them opportunities for ongoing training and skills development, as well as nurturing supervision.
- Survey adolescent clients to determine whether they prefer staff who come from their communities, are of the same gender, and/or reflect their ethnic and cultural backgrounds.
- Provide any staff who interact with adolescent clients with training opportunities to learn additional skills for working with teens. Having skilled, non-judgmental staff who reinforce adolescents' responsible behavior is important. Continuing education efforts are key for assuring the provision of quality care.

**8. Outreach Services** – The adolescents at highest risk for sexual and reproductive health risks are often the ones who do not seek services. It is important to conduct pro-active community outreach, offering services that are accessible and acceptable for these harder to reach youth.

- Establish a presence in the community by advertising services and providing community health education.
  - Send outreach workers to approach youth in their own neighborhoods (including schools, recreation centers, popular places where young people meet, etc.).
- Work to reach both males and females. Even if your program does not offer clinical family planning services to males, it is key to fully engage them, as men are extremely influential in determining whether or not their partner will use contraceptives consistently.
- Partner with service agencies already working with homeless or street youth to develop health education messages or harm reduction programs for their clients.
- Combine resources with other service agencies to provide screening or testing opportunities (through mobile vans or temporary clinic set-ups) in neighborhoods with high-risk youth. To attract clients offer incentives, such as key-chains, bookmarks, plastic water bottles, etc. Use these opportunities to let clients know where regular clinic facilities are located.
- Work with your local health department or private companies to obtain urine-based test kits for gonorrhea and chlamydia to use in community settings. These non-invasive tests are more practical to administer in non-clinical settings, for example discretely in park and recreation setting and less uncomfortable for clients, as compared to traditional venues such as STD clinics which youth may avoid.



### Assessing Teen-Friendliness on a Community-wide Basis

In parallel with suggestions for making individual agencies more teen friendly, community-wide coalitions may also develop a system for maximizing the identification of teen-friendly services. For example, a guide to community services could be printed listing hours of services, telephone numbers, addresses, costs, etc. Printing this information on posters or brochures that youth receive and keep, (e.g. on the back of school sports schedules, concert listings, class lists, etc.), will increase the visibility of these services.

The availability of web-pages and text-messaging also represent important new, relatively low cost, and extensive outreach strategies that are in sync with adolescents' patterns of technology use. The ability to coordinate services across geographic areas would also help agencies recognize where current gaps exist and how best to address them. Programs should work closely with schools, recreation programs, and other community services to identify opportunities where such information can be integrated

### Taking Next Steps

Once you have completed the assessment, identified the program areas that could be improved and prioritized the action steps for enhancing your program's services, you should be ready to start implementing your ideas. It is important to have a plan for evaluating the success of your efforts in order to determine if the

effort to change the program is worth continuing or what part of the new strategies need modification to meet intended goals.

A good evaluation process includes the following:

- Identify an important health or process outcome goal that will be affected by the change in service delivery planned. For example, if you are implementing new referral linkages, an important outcome may be the number of clients that receive services at the referral agency; if you are starting a campaign to raise awareness about chlamydia screening services, screening coverage could be a measurable outcome.
- Decide how this outcome will be monitored, (e.g., will you use a survey to measure client satisfaction, or use existing administrative data, such as the billing system, to compare the volume of clients served both before and following the implementation of the new strategies).
- When possible, implement the service change during a period when few other changes in service delivery are planned. This will allow for greater opportunities to attribute the outcome to a specific intervention.
- Plan an evaluation period that gives the new service change time to take effect, (e.g., if your program offers new services, make sure the follow-up evaluation occurs after enough time has passed for clients to hear about and use of the services).
- Use a consistent method for measuring outcomes over time. While your desired outcome may be a reduction in teenage births, the incidence of chlamydia and HIV infection among teenagers and young adults, other short term measures can help provide insights as to whether longer term outcomes could be accomplished, in the future, (e.g., such as the number of clients served, the types of contraceptive methods provided, the number of clients who report using more effective contraceptive methods consistently, as well as a reduction in the number of sexual partners).

## Linking Services to Outcomes

An important step in planning service delivery changes is to link the improvements to outcome data for adolescent clients. Monitoring health outcomes helps you assess whether these improvements are in fact contributing to the results you wish to achieve.

To be able to evaluate the impact of your program's efforts on outcomes that matter, measure the baseline or starting level prior to the implementation of the program changes. For example, tracking screening outcomes both before and after a urine-based testing program is introduced into a community or an outreach campaign is introduced allows for some measurement of your program's success.

If outcome goals are not reached, it would require you to review:

- The quality of the intervention implemented (e.g., were all the components fully implemented as planned?);
- Whether services were adequately advertised or promoted so substantial numbers of adolescents had increased knowledge regarding the availability of services;
- The fit of the intervention and the clients' needs (e.g., did you seek the input of young people in creating and piloting the strategy?);
- The strength of the intervention being implemented (e.g., was the referral mechanism sufficient to expect change?);
- The "reach" of the intervention (e.g., did it reach a sufficiently large enough number of potential clients for a change to be detectable?); and
- The timing of the intervention (e.g., have you allowed for sufficient time to establish the intervention so that it is well known in the community and any initial implementation problems have been resolved. Seasonal variation may also affect implementation.).

Once you have done your analysis, you may decide to modify, enhance, or even begin all over again. Examples of important outcomes include, but are not limited to:

### Short-Term Outcomes

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- Increased numbers of adolescent clients served
- Increased proportion of adolescent clients completing a risk assessment
- Increased proportions of adolescent clients screened for chlamydia
- Increased proportion of client following-up on referral appointments
- Increased numbers of clients receiving condoms

## Interim Outcomes

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- Increased consistent use of effective birth control methods
- Increased use of condoms
- Decreased numbers of sexual partners in the last year
- Decreased proportion of adolescents with concurrent sexual partnerships
- Longer waiting times between new sexual partnerships

## Long-term Outcomes

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- Decreased numbers of positive STI and HIV tests
- Decreased numbers of positive pregnancy tests
- Decreased number of teen births

By tracking changes in these types of short and longer-term outcomes, changes in service delivery strategies can be improved with evidence-based program planning. Demonstrating outcomes is an important justification for expending resources necessary for service improvements. It is also critical that established outcomes are measurable and logically linked to the types of interventions that are implemented. For example, without an adequate system in place to track follow-up to referrals and without staff commitment to make referrals, including counseling the teens as to the importance of the referral, there is greater likelihood that meeting the short-term outcome of increasing the proportion of successful referrals would not be reached.

### Suggested Outcome Indicators

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Several national health organizations have designated a set of key health indicators by which to evaluate prevention efforts and service delivery impact. Using these guidelines helps to assure that your program's efforts are in concert with concurrent national and state efforts to improve the health of adolescents. These measures include:

**Healthy People 2010: 21 Critical Objectives for Adolescents and Young Adults** includes four sexual and reproductive health goals:

- Reduce pregnancies among adolescent females from 66 to 43 per 1000.
- Reduce the number of cases of HIV infection among adolescents and adults.
- Reduce the proportion of adolescents and young adults with *chlamydia trachomatis* infections to 3%.
- Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active from 85% to 95%.

To find out more about all 21 of these adolescent specific objectives go to <http://youth.ucsf.edu/nahic>.

**The National Committee for Quality Assurance, Health Employer Plan Data and Information Set (HEDIS)**, encourages managed care organizations to monitor a number of important process outcomes. Annual chlamydia screening among sexually active women ages 15-25 is one of their adolescent indicators measuring quality. For more information go to: [www.ncqa.org/Programs/HEDIS/](http://www.ncqa.org/Programs/HEDIS/)

## **Population Based Health Outcomes**

There are two levels of health outcome data that can assist in program planning. The first is data that is specific to your clients, their experience and health status, while the second is population based-data on adolescents in the larger population that may or may not be accessing care.

### **Gathering Comparative Population-based Health Outcome Data**

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Population-based data are important in assessing need, planning outreach services, and serving as a comparison to the program-specific data. Trends in STI and birth rates occurring among adolescents in the community as a whole can provide valuable information about the impact of changes in service delivery, as well as emerging needs or trends that will require additional programmatic efforts. For example, demographic trends indicating that there will be an increase in the number of teens living in a community will raise the possibility of a greater need for services (if existing patterns of sexual activity remain steady). Furthermore, because STIs and HIV are communicable diseases, early diagnosis and treatment of infections in one group of adolescents becomes primary prevention for a group of individuals whom are not yet infected. Countywide, statewide, or even nation-wide data form the basis of comparison for your program-specific data to determine if trends within your clinic population reflect what is occurring elsewhere.

Many types of population-based health outcome data are readily obtained through on-line resources or by contacting your local health department. In addition, many large national surveys funded through government or private foundations provide reports of their results online. Spending some time with a general search engine, using search terms such as “Adolescent Health,” to identify these information sources can be very valuable. A number of specific sites are mentioned later in this chapter.

Many of the sources of data listed in this Guidebook are specific to California. However, if you are doing a program assessment in another state, you may find similar resources from a local or state health agency in your area.

### **Local health Department Resources in California**

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In California, each county has a designated STD controller who is responsible for disease control activities in his or her health jurisdiction. These responsibilities include prevention efforts, ensuring adequate clinical services are available, investigating outbreaks of STDs, and monitoring trends in reportable diseases. The STD controller is an important resource for finding out more information about what is happening in your county. To contact the STD controller in your health jurisdiction, see the Resource section of the Guidebook.

Other local health department resources in California include the county AIDS Director and the Health Officer. In some smaller health jurisdictions, the same person may be responsible for several or all of these duties. To find out if there is a health department website for your county, go to [www.dhs.ca.gov](http://www.dhs.ca.gov) ⇒ Links to Online Health Resources ⇒ State/Local Government.

## Teen Births

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At the national level, a number of resources for birth data exist:

The CDC website includes a Reproductive Health Information Source available at [www.cdc.gov](http://www.cdc.gov) ⇒ Health Topics A-Z ⇒ Reproductive Health Information Source ⇒ <http://www.cdc.gov/nccdphp/drh/>

The National Campaign to Prevent Teenage Pregnancy (at [www.teenpregnancy.org](http://www.teenpregnancy.org)) offers numerous fact sheets and highlights key initiatives and programs related to reducing teen pregnancy; and

Advocates for Youth ([www.advocatesforyouth.org](http://www.advocatesforyouth.org)), an organization dedicated to helping youth make informed and responsible decisions about their sexual and reproductive health, maintains a “Facts & Figures” page as well as other helpful information.

Data on teen births in most states are compiled by an office of vital statistics and monitored by the Maternal Child and Adolescent Health (MCAH) branch. In California, the MCAH Branch falls within the Department of Public Health. Teen birth data for California may be viewed on-line at [www.cdph.ca.gov](http://www.cdph.ca.gov) ⇒ Data ⇒ Statistics ⇒ Adolescent Sexual Health Data.

## Teen pregnancy vs. birth data

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It is important to distinguish between teen pregnancies and teen births. These terms are often used interchangeably, but have very different meanings. For many adolescent health providers and policy makers, the health outcome of primary interest is unintended pregnancy. However, most teen pregnancy data represent only estimates based on the number of teen births, adjusted for the approximate number of miscarriages and abortions that may have occurred in this population. Counts of both miscarriages and abortions are quite imprecise as there is no complete reporting system for monitoring either incident nationally. Some states do report pregnancies, although these data are likely to be underestimates.

For these reasons, the most reliable data available are on teen births. Teen births are counted as those births occurring among females ages 10-19 (with those occurring among girls aged 10-14 making up a small percentage of the total.) These data are well-defined and fairly complete, as is most vital statistics reporting in the U.S.

## Sexually Transmitted Infections

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Data on STIs are readily available on a county, state, and national level. Sexually transmitted infection rates that are monitored by most local health departments include syphilis, gonorrhea, chlamydia, and pelvic inflammatory disease.

As one of its many roles, the Centers for Disease Control and Prevention (CDC) acts as a coordinating body of health statistics, collating state-level data into a centralized national report. For national-level and comparable state data go to [www.cdc.gov](http://www.cdc.gov) ⇒ Data & Statistics ⇒ Sexually Transmitted Diseases. The CDC website also provides links to many of the state health department websites that provide additional state-specific data.

Most states also have a system for collecting these data across counties and making them available in a comprehensive annual report. In California, the

MCAH Branch falls within the Department of Public Health. Sexually Transmitted Infection data for California may be viewed on-line at [www.cdph.ca.gov](http://www.cdph.ca.gov) ⇒ Data ⇒ Statistics ⇒ Adolescent Sexual Health Data.

### **HIV/AIDS**

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Just as STI data are available online from many state health department sites, so are statistics and trends for AIDS cases. In areas most heavily affected by AIDS, monitoring trends in the AIDS epidemic is a high priority activity. Extensive reports, showing gender, age, and high-risk group status, are usually available. In California, these data are available at the Department of Health Services website: [www.dhs.ca.gov](http://www.dhs.ca.gov) ⇒ Statistical Resources.

### **HIV vs. AIDS data**

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While all state health departments mandate AIDS case reporting, data on HIV infections are more difficult to obtain than STI and birth data. Only 35 states, not including California, currently use a system of named HIV reporting. Thus reliable data on HIV infection are not available in 25 states, except through periodic surveys in some areas. Due to the concern over patient confidentiality, those systems monitoring HIV cases are believed to be heavily under reported by providers.

Trends in AIDS cases are difficult to translate into current trends in HIV infection due to the several year lag time before the development of AIDS. Advances in AIDS care and drug therapy also complicate the extrapolation from trends in HIV to AIDS. Data from anonymous HIV testing sites are difficult to interpret as well. These data lack unique identifiers that differentiate individuals whom are tested multiple times despite receiving a positive result.

Among adolescents, especially those in small counties, HIV is relatively rare. Changes in small case numbers are difficult to distinguish from random fluctuations or changes in volume of voluntary testing. However, because many of the risk behaviors associated with the sexual transmission of HIV are the same as those for STIs, trends in gonorrhea and chlamydia rates may serve as helpful indicators of the increasing or decreasing risk for HIV among adolescents.

### **Other Adolescent Health Data**

The CDC website offers a wealth of information on many health issues important to adolescents which can be accessed at <http://www.cdc.gov/nccdphp/dash/>. Links to data and reports from the national Youth Behavioral Risk Survey and other useful documents are also available there at [www.cdc.gov](http://www.cdc.gov) ⇒ Health Topics A-Z ⇒ Adolescents & Teens or through the Division of Adolescent and School Health (DASH).

### **Interpreting Health Outcome Data**

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By completing the program assessment on sexual and reproductive health service delivery in your program or community, you will be able to identify areas where new services and efforts should be placed. By monitoring changes in health outcomes, it may be possible to evaluate the impact of service delivery changes in the population you are trying to serve. This type of outcome data is an important advocacy tool to justify a need for new programs or demonstrate the effectiveness

of current programs. At the same time, there are many different factors, for example, economic indicators, unrelated to service delivery that may impact rates of disease or births. For these reasons, interpreting health outcome data and using these data appropriately is important for program planning and maintaining program credibility with funders and community members.

It is also important to be realistic about what any one program can do to have a strong impact on population-based data. Clearly improving programs is key to assuring that teens have the access to the types of services they need. However, without additional efforts underway within a specific community, it is likely that these numbers may not shift significantly within relatively short periods of time. Thus, at a minimum determining interim outcomes helps programs gauge that they are on the right pathway.

### **Cases vs. Rates**

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You will most frequently encounter two types of health outcome data: case numbers and rates. Case numbers represent exact counts of people diagnosed with the disease. Rates, which are often reported as percentages or as per 100,000 people, divide the case numbers by the total population living in the geographic area to provide a standardized measure of how frequently the specific disease occurs in a population. This is important because California counties have very different population sizes and densities. If 10 cases of HIV are reported in a small town, this would be a much more alarming than if 10 cases were reported in a large metropolitan area.

Sometimes rates can make the number of cases appear larger than they really are, especially when used for areas with small numbers of people. This is because when reporting rates in a standardized way, (e.g., per 100,000 people), it may be necessary to multiply the number of cases by a large factor to calculate the number of cases that would be reported if the total population were 100,000.

Example:

If a town with 1000 adolescent females reported 85 teen births in a one year, the rate for that year would be presented as 8500 teen births per 100,000, i.e.,  $85 \times (100,000/1000)$ . If you didn't know that the size of the town was only 1000 adolescent females, you might think there were many more teen births than there really are.

### **Cautions to interpretation of health data**

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When interpreting disease or birth rates, it is important to understand who gets counted in the denominator. Most routinely reported rates use the total population, rather than only those that are at risk. These inflated denominators underestimate the true rate of disease or births among sexually active adolescents.

Example:

The overall rate of reported chlamydia among California females ages 15-19 in 2000 was 2.1%. A recent behavioral survey of high school students suggests that approximately 45% of girls in this age group are sexually active. If these behavioral data were applicable to California then the rate of chlamydia among females ages 15-19 that are sexually active and at risk of acquiring a disease is really  $2.1 \div 0.45$  or 4.7 percent.

Furthermore, a significant proportion of chlamydia and gonorrhea infections are asymptomatic, and may go undiagnosed and unreported. For this reason, reported STI rates, (e.g. those maintained by health departments), are believed to be conservative estimates of true levels of infection.

It is also important to remember that trends at the state and county level are not necessarily representative of what is happening in your community. Reviewing rates and case numbers broken down by smaller areas, such as zip codes or census tracts, will be more helpful in assessing the impact of service delivery changes adopted by a single program or a small group of programs. Many health departments track specific rates and case numbers for adolescents because this age group represents an important risk group. It may be worthwhile to contact your local STD controller or health officer to see if this level of data is available for your area.

### **The Importance of Monitoring Behavioral Data**

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Behavior change sometimes results from shifts in social norms or the accessibility of products, such as condoms, that impact the likelihood of practicing safer sex. In addition to measuring behavior change, the effects of these environmental factors are important to understand and track. Conclusions about any health outcome data should incorporate changes in the community in addition to changes in sexual risk taking. Some examples of these types of factors include:

- The availability of new contraceptive methods, (e.g. the shot, implant, or patch modes of hormonal methods), may change frequency of condom use;
- Mass media campaigns presenting effective messages about communicating with sex partners about risk may change trends in sexual behavior;
- Increased recreational programs for adolescents, such as sports venues, or youth centers may provide positive outlets for adolescents' time and socializing;
- A change in availability of illegal drugs or alcohol for under-age youth in a neighborhood may affect substance use and high risk behaviors including sexual behaviors; and
- Changes in welfare reform or other social service policies may influence childbearing patterns.

Some factors do not alter the transmission rates of STI and HIV, but do lead to increased detection of disease and therefore apparent increases or decreases in rates. Some examples of these factors include:

- Increased or decreased availability of screening services;
- Campaigns to increase adolescents' awareness of the need for screening;
- Special efforts to conduct outreach and screen high risk populations; and/or
- The adoption of less invasive or more sensitive diagnostic tools.

Many studies have looked at behavioral risk factors associated with the transmission of STIs and HIV and teen pregnancy. Key factors include age at first time of sex, use of condoms at first and last sexual encounter, and the number of

lifetime and recent partners. These behavioral outcomes are important not only because they serve as proxies for health outcomes, but can signal the need for an intervention before adolescents become infected, pregnant or make a partner pregnant.

There are numerous behavioral surveys conducted on a nationally representative sample of adolescents that provide both the results and survey instruments. These sources include:

- The Youth Risk Behavior Survey (YRBS), conducted in a large number of high schools throughout the country under the auspices of the CDC on a variety of health topics, including a module on sexual behavior. To access data for your state, go to [www.cdc.gov/nccdphp/dash/yrbs](http://www.cdc.gov/nccdphp/dash/yrbs)
- The National Survey of Adolescent Men (NSAM) provides data on a national sample of males ages 15-24. This survey focuses primarily on males' sexual behavior and condom use. For more information see [nichd.nih.gov/about/cpr/dbs/res\\_national3.htm](http://nichd.nih.gov/about/cpr/dbs/res_national3.htm) ;
- The National Survey of Family Growth (NSFG) focuses on the sexual behaviors and contraceptive use patterns of women 15-44 (<http://www.cdc.gov/nchs/nsfg.htm>); and
- The National Longitudinal Adolescent Health Survey (Add Health), a national, multi-wave, study with a representative sample of adolescents covers a variety of health issues (<http://www.cpc.unc.edu/addhealth/>).

In California, there is an important behavioral survey resource administered through schools, called the California Healthy Kids Survey (CHKS). In addition to addressing a wide range of risk behaviors, the CHKS includes an optional module focusing on sexual risk behaviors (although only a small subset of schools currently collect this data). This survey is funded through the California Department of Education, and West Ed, (a non-profit research agency) assists schools in administering and tabulating the results. To find out more about the CHKS and what is being done in your local area, go to [www.wested.org/hks](http://www.wested.org/hks).

Whether or not the CHKS is used in your school district, the instrument developed for CHKS can also be adapted and used with your program's adolescent clients. In addition to the Healthy Kids Survey instrument, the California STD Control Branch has developed a similar baseline risk assessment tool for specific use in community-based organizations. For more information on how to obtain this instrument and assistance in conducting a survey with your clients, you can contact Paul Gibson, at [pgibson@dhs.ca.gov](mailto:pgibson@dhs.ca.gov).

### **Encouraging Schools to Collect Sexual Behavioral Data**

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If the Healthy Kids Survey does not currently take place in your school district and/or your school does not use the sexual risk behavior module, your organization can help to make school board members and parents in your community aware of the importance of participating in this data collection effort.

Since the majority of adolescents are enrolled in schools, these settings become a critical location for collecting information on adolescent sexual behavior data, as well as other risk and protective behaviors. The data collected through the CHKS (or other adolescent survey) can assist in planning more effective programs and monitoring changes in adolescent risk behavior at the school, district, county, and state levels. The CHKS system can also help schools to obtain or maintain certain types of federal funding which require schools to monitor these types of

behavioral data. The CHKS tool is also useful for collecting information from out-of-school, incarcerated, homeless or other high-risk youth.

Several recent studies show that parents support sexuality education and related services in schools to help their children learn to protect themselves and make good decisions in regards to sexual behavior. Conducting a risk assessment through a behavioral survey like the CHKS is an important first step for tailoring these services to meet the needs of a specific group of adolescents. For those parents who do not want their children to participate, the option to refuse to give consent remains. However, traditionally, very few parents choose to opt out of such data collection efforts, especially if parents are included in the decision-making process related to collecting this information.

### **Summary**

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Providing integrated and teen-friendly services requires firm commitment and dedication by communities. As described in this guide, a number of steps can be fulfilled in helping individual agencies, as well as agencies across a whole community assess their responsiveness to improving service integration and teen-friendliness. Engaging professionals, youth and other stakeholders in this process is key to assuring that relevant data are collected, a baseline established, and a plan of action is implemented based upon findings. While clearly not all agencies or communities may be able to make sweeping changes, we hope that this guide offers support and encouragement to identify doable steps aimed at improving the quality of services available to young people. Such an investment is important if we, as a society, are truly committed to helping young people reduce their sexual risk-taking behaviors and in turn, improving communities as a whole.

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California Department of Public Health's Family PACT program.

[www.familypact.org](http://www.familypact.org)

The National Campaign to Prevent Teen and Unplanned Pregnancy, Teen Pregnancy, Birth and Sexual Activity Data

<http://www.thenationalcampaign.org/national-data/default.aspx>

# RESOURCES

## Data

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Advocates for Youth ([www.advocatesforyouth.org](http://www.advocatesforyouth.org)), an organization dedicated to helping youth make informed and responsible decisions about their sexual and reproductive health, maintains a “Facts & Figures” page.

The Youth Risk Behavior Survey (YRBS), conducted in a large number of high schools throughout the country under the auspices of the CDC on a variety of health topics, including a module on sexual behavior. To access data for your state, go to [www.cdc.gov/nccdphp/dash/yrbs](http://www.cdc.gov/nccdphp/dash/yrbs)

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## Training

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California STD/HIV Prevention Training Center’s website features information about training programs designed to enhance the STD/HIV knowledge and skills of medical, health, and community professionals. <http://www.stdhivtraining.org>

The CDC website includes a Reproductive Health Information Source available at [www.cdc.gov](http://www.cdc.gov) ⇒ Health Topics A-Z ⇒ Reproductive Health Information Source ⇒ <http://www.cdc.gov/nccdphp/drh/>

## **Youth Information**

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The Adolescent Health Collaborative website features a comprehensive range of data and resources related to adolescent health issues. <http://www.californiateenhealth.org>

CDC's Division of Adolescent and School Health (DASH) website <http://www.cdc.gov/nccdphp/dash/index.htm> Adolescent and provides current information and research regarding the health concerns and issues of high school students.

Georgetown University's National Center for Education in Maternal and Child Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (2nd ed., rev.) (1994; 2000; 2002) Bright Future Guidelines consists of 29 recommended health visits (newborn through 21). The guidelines provide key health questions, developmental observations or milestones, scheduled immunizations and screening procedures, and specific guidance for families on anticipated changes their child will experience in the approaching stage of development. <http://www.brightfutures.org/guidelines.html>

The National Adolescent Health Information Center (NAHIC) <http://youth.ucsf.edu/nahic>.

## **Provider Resources**

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The Adolescent Health Working Group's website provides teen friendliness information and materials for providers working with adolescents. <http://www.ahwg.net>

The American Medical Association's Guidelines for Adolescent Preventive Services (GAPS) is a comprehensive set of recommendations that provides a framework for the organization and content of preventive health services. The GAPS recommendations were designed to be delivered, ideally as a preventive services package, during a series of annual health visits between the ages of 11-21. <http://www.ama-assn.org/ama/pub/category/1980.html>

The California Chlamydia Action Coalition offers a provider tool kit for chlamydia in California including a section on talking with adolescents. <http://www.ucsf.edu/castd/>

The National Committee for Quality Assurance, Health Employer Plan Data and Information Set (HEDIS), encourages managed care organizations to monitor a number of important process outcomes. Annual chlamydia screening among sexually active women ages 15-25 is one of their adolescent indicators measuring quality. For more information go to: [www.ncqa.org/Programs/HEDIS/](http://www.ncqa.org/Programs/HEDIS/)

"The 1-2-3's of Family PACT Provider enrollment:"

<http://www.dhs.cahwnet.gov/PCFH/ofp/Documents/PDF/FamPact/123offamilypactproviderenrollment.pdf>

For more information, call 1-800-257-6900

The National Campaign to Prevent Teenage Pregnancy (at [www.teenpregnancy.org](http://www.teenpregnancy.org)) offers numerous fact sheets and highlights key initiatives and programs related to reducing teen pregnancy.

Planned Parenthood Federation of America (PPFA) provides comprehensive reproductive health information including a focus on teen issues. <http://www.plannedparenthood.org/>

U.S. Preventive Services Taskforce's Guide to Clinical Preventive Services <http://www.ahcpr.gov/clinic/cpsix.htm>

Department of Health and Human Services (HHS), Health Insurance Portability and Accountability Act (HIPAA) <http://www.hhs.gov/ocr/hipaa/>

## APPENDICES: Sample Questionnaire Modules

These modules are provided as guides for interviews or written surveys conducted during your program assessment. The purpose of each of the Provider and Adolescent Modules are described below to help you select the modules that make sense for your project. Once the modules are selected, they should be adapted to better apply to the programs in your assessment. You can also decide how these modules would be administered, whether as an in-person interview or written format. Additional modules may be necessary.

### PROVIDER MODULES:

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- 1. PROGRAM MISSION, STRENGTHS, AND INNOVATIONS.....54**  
This module reviews the positive achievements of the program. It provides an opportunity to assess whether all share the same mission, for example, whether providers and adolescent clients would agree on the strengths of the program. By asking about program innovations (those that do or do not work), the programs can share innovations across programs within the same community.
- 2. BARRIERS, SOLUTIONS, AND FACILITATORS.....55**  
This module asks providers to describe both barriers and solutions to service integration. To organize the discussion of barriers, and to identify the more common issues regarding resources, providers are first asked to describe resource barriers, then social/political barriers. Finally, other issues perceived as barriers are solicited. The final two questions are intended to cull lessons learned from the providers' experiences of what works and what doesn't work in service delivery.
- 3. VISION FOR AN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTHSYSTEM.....57**  
This module aims to create consensus about what constitutes a comprehensive adolescent sexual and reproductive health system.
- 4. INVOLVEMENT OF TEENS AND PARENTS IN PROGRAM PLANNING.....59**  
Community input about program design, especially from adolescent clients and their parents, can make a substantial difference in making services accessible and increasing utilization. This module asks providers about how clients and parents are involved in program planning.
- 5. DEMOGRAPHICS.....60**

To better understand your sample of providers, use this module to collect key participant characteristics. Depending on the number of providers at each program, it may be possible to identify individuals from these characteristics: use caution when reporting any of these individual characteristics when reporting specific comments.

## **ADOLESCENT MODULES:**

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### **1. ACCESSING SERVICES.....61**

This interview starts with questions that are not very personal, in order for the interviewer and client to have a chance to become comfortable talking with one another. These questions are helpful for assessing under what circumstances clients come to the program site.

### **2. CLIENTS' OPINIONS ABOUT THE PROGRAM.....62**

These questions are designed to elicit client opinions about the services offered by this specific program. These responses can help programs identify successes and areas for improvement. Program providers may also be able to validate self-evaluation of the program's strengths and weaknesses.

### **3. GENERAL BARRIERS TO CARE AND TEEN FRIENDLINESS ISSUES.....63**

This module focuses on what clients perceive as barriers and ways to make services attractive, (e.g., teen friendly). Response categories are arranged by themes, (e.g., logistics, cost and transportation, staff-client interactions, confidentiality, etc. ). Some responses may be collapsed or omitted because they may not apply to a specific program. Note that the response categories match those on the corresponding question on Provider Module – 3.

### **4. MISSED OPPORTUNITIES & KNOWLEDGE OF SERVICES.....65**

One of the key issues in assessing integration efforts in clinical settings is how well program guidelines are met in actual practice. These questions are meant to be asked after a client has seen a provider to get a sense of client's comfort level.

### **5. WHO TEENS CAN TALK TO ABOUT SEX.....67**

This module will help to identify whether parents or guardians are an important source of information or support for adolescent clients at this program. Those parents that provide social support around sexual and reproductive health concerns can be important allies to programs trying to provide these services.

### **6. CONCLUSION AND DEMOGRAPHICS.....69**

## **STRUCTURAL SURVEY MODULES:**

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**1. CLIENT DEMOGRAPHICS.....70**

**2. AVAILABILITY AND SCOPE OF CLINICAL SERVICES.....72**

**3. AVAILABILITY AND SCOPE OF NON-CLINICAL SERVICES.....75**

**4. FUNDING SOURCES – CLINICAL.....77**

**5. PRACTICE GUIDELINES AND POLICIES – CLINICAL PROGRAMS..78**

**6. STAFFING – CLINICAL PROGRAMS.....80**

**7. STAFFING – NON-CLINICAL PROGRAMS.....82**

**8. TEEN FRIENDLINESS INVENTORY – SHORT SURVEY.....83**

**Provider Modules**

**1. Program Mission, Strengths, and Innovations**

Some people have suggested that integrated STD/HIV/ pregnancy prevention and care services are a particularly promising approach for adolescents. There are many different ways to think about integration, but in this interview I am talking specifically about integrating services from a client’s perspective. By this we mean: 1) STD, HIV, and pregnancy risk assessments are routinely conducted when teen clients come in for appointments and 2) clients have access to STD, HIV, and family planning services during all service hours and at the same facility.

**Program Mission**

1. Does your program have a specific mission or goal? Please describe it. (check all that apply)

- a. to serve teens
- b. to provide quality clinical services
- c. to serve hard-to-reach populations
- d. to prevent pregnancy
- e. to provide integrated services, 1-stop
- f. Other: \_\_\_\_\_

Specify population: \_\_\_\_\_

**Program Strengths**

2. How does your organization meet adolescents’ sexual and reproductive health needs? (check all that apply)

- a. creating a teen friendly environment
- b. providing high quality of services
- c. comprehensive scope of services
- d. providing confidential services
- e. using innovative outreach strategies
- f. partner notification/treatment services
- g. ability to retain teen clients
- h. strong links w/ other service providers
- i. provider-client relationship
- j. improving parent-child communication
- k. support from community
- l. Other: \_\_\_\_\_

**Innovations**

3. Have you tried any innovative approaches to providing adolescent sexual and reproductive health services? Can you tell us about them and whether or not they have worked?

- a. no innovations attempted
- b. peer education programs
- c. media campaigns
- d. parent-child relationship development building
- e. condom distribution in non-clinic settings
- f. screening in community based settings
- g. leadership and communication skill
- h. other: \_\_\_\_\_

4. How are services promoted or advertised among adolescents?(check all that apply):

- a. yellow pages
- b. ads in public transportation
- c. newspaper ads
- d. radio spots
- e. flyers
- f. health fairs/events
- g. presentations in classrooms
- h. community health outreach workers(CHOW)
- i. Web page for agency
- j. “My Space” or other internet communication
- k. other: \_\_\_\_\_

Comments on successes or problems encountered:

**2. Barriers, Solutions, and Facilitators**

---

Providing sexual and reproductive health services to adolescents can be very challenging. Please describe some of the most significant barriers that you have encountered.

**Resource Barriers**

1. What resource barriers has your agency encountered? (check all that apply)

- a. None
- b. Time
- c. Money/funding
- d. Staff
- e. other/comments: \_\_\_\_\_

**Political/Social Barriers**

2. What political or community climate barriers has your agency faced? (check all that apply)

- a. None
- b. Negative attitudes of general community
- c. Community lacks awareness/ community perceives these issues as irrelevant
- d. Opposition from community leaders:
  - a1. school officials
  - a2. elected officials
  - a3. religious leaders
  - a4. other: \_\_\_\_\_
- e. Parents' discomfort with services offered
- f. Other/comments: \_\_\_\_\_

**Teens Access to Care**

3. What do you think are the major barriers for adolescents to accessing sexual and reproductive health care? (check all that apply)

- a. none
- b. paying for services
- c. lack of transportation
- d. don't know where to go
- e. services are unavailable
- f. fears clinical procedures
- g. finding a provider they trust
- h. no place specific for teens
- i. hard to talk about these topics
- j. unsupportive parents/adults
- k. don't want parents to find out
- l. don't want friends to know
- m. don't want to be judged
- n. in denial about health risks
- o. other: \_\_\_\_\_

**Other Barriers**

4. Assuming that you had unlimited resources and a supportive political environment, what would be the other barriers to providing these services to adolescents?

- a. None
  - b. Competing concerns of teens, e.g., violence, substance use, family conflict
  - c. Keeping up-to-date with adolescent health guidelines and recommendations
  - d. Linking adolescent health providers to provide consistent, seamless services
  - e. Other: \_\_\_\_\_
- or describe any of the above
-

**Solutions**

5. What have you or members of your staff done to overcome these barriers you mentioned?  
How did it work?

- a. Nothing
- b. Improve communication with community
- c. Involve of community/clients in program planning
- d. Creative use of resources (please explain: \_\_\_\_\_)
- e. Other:

Describe examples of how this did or did not work:

**Facilitators**

6. We've talked about some of the things that can make it difficult to provide services for adolescent sexual and reproductive health needs. However, there are often informal and formal leaders who have been particularly helpful in advancing program goals. Please list the types of community members who have been supportive in advancing your program goals. (check all that apply)

- a. Community leaders:
  - a1. School officials
  - a2. Elected officials
  - a3. Religious leaders
  - a4. Other:

- b. Parents
- c. Health Providers
- d. Clinic Director/Manager
- e. Other: \_\_\_\_\_

Describe examples of how this did or did not work:

### 3. Vision for an Adolescent Sexual and Reproductive Health System

---

**Restructure/  
Expand**

1. Based on your experiences working with adolescents, how would you restructure or expand your community's system for providing sexual and reproductive health services for adolescents?

- a. No changes necessary
- b. Greater integration of sexual and reproductive health services
- c. More effective efforts to address violence
- d. More services for males
- e. More providers trained to work with adolescents
- f. Other:

---

Describe any of the above strategies that may be useful to pursue:

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2. Please describe how a community wide system would impact your own agency.

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3. Please describe how this system would function within your county or state.

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4. Has there been discussion in your agency about integrated services? (see description on page 54)

- a. Yes                       b. No

**Success in Service Integration**

5. Thinking of integration as a continuum, on a scale of 1-5, with **5 being the most integrated**, to what extent has your agency integrated adolescent sexual and reproductive health services? Just to be clear, we are asking you to evaluate your success with integration, not to evaluate how well your services are provided.

	<b>Clinical Services (1-5 range)</b>	<b>Health Education/ Health Promotion (1-5 range)</b>
<b>ALL THREE AREAS</b>  (FAMILY PLANNING, STD & HIV)		
If program only offers two of the three service areas, rating can be given separately		
<b>Family Planning &amp; STDS</b>		
<b>STD &amp; HIV/AIDS</b>		
<b>Family Planning &amp; HIV/AIDS</b>		

6. Based upon your agency's experience in service integration, what lessons have you learned in attempting to integrate care?

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**4. Involvement of Teens and Parents in Program Planning**

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1. What has been the experience of your agency in including adolescents and/or parents in the development of your program services and/or strategies? First, please answer the role of adolescents.

**Teens  
Involved**

Adolescents:

- a. Not included
  - b. Plans to be included in the future
  - c. Formal inclusion:
    - iii a. advisory group
    - iii b. peer providers/event planners
    - iii c. program evaluation (e.g. focus groups, client surveys)
  - d. Informal inclusion (Describe): \_\_\_\_\_
- \_\_\_\_\_

**Parents  
Involved**

Parents:

- a. Not included
  - b. Plans to be included in the future
  - c. Formal inclusion:
    - iii a. advisory group
    - iii b. community meetings
    - iii c. program volunteers
    - iii d. program evaluation (e.g. focus groups, surveys)
  - d. Informal inclusion (Describe): \_\_\_\_\_
- \_\_\_\_\_

**5. Demographics**

**Provider/  
Admin-  
istrator  
Demo-  
graphics**

Now I would like to ask you a few questions about yourself. If you feel uncomfortable about any of these questions, please feel free not to answer them:

**1. What is your specific area of education or training?**

- |        |   |         |   |
|--------|---|---------|---|
| MD:    | <input type="checkbox"/> a. Adolescent Medicine   | Masters | <input type="checkbox"/> g. Social Work                 |
|        | <input type="checkbox"/> b. OB/GYN                | Level:  | <input type="checkbox"/> h. Marriage & Family Counselor |
|        | <input type="checkbox"/> c. Other MD: _____       |         | <input type="checkbox"/> i. Public Health               |
| Mid    | <input type="checkbox"/> d. Nurse Practitioner    | Comm/   | <input type="checkbox"/> j. Health Education            |
| Level: | <input type="checkbox"/> e. Registered Nurse      | Educ:   | <input type="checkbox"/> k. Outreach Worker             |
|        | <input type="checkbox"/> f. Physician's Assistant | Other:  | <input type="checkbox"/> l. _____                       |

**2. How many years have you been providing services to adolescents?**

\_\_\_\_\_ years

**3. What year did you complete your professional training?**

Year: \_\_\_\_\_

**4. How old are you?**

- |                                      |                                   |
|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> a. Under 25 | <input type="checkbox"/> e. 41-45 |
| <input type="checkbox"/> b. 25-30    | <input type="checkbox"/> f. 46-50 |
| <input type="checkbox"/> c. 31-35    | <input type="checkbox"/> g. 51-55 |
| <input type="checkbox"/> d. 36-40    | <input type="checkbox"/> h. 56-60 |
|                                      | <input type="checkbox"/> i. 61+   |

**5. With what race-ethnicity/ies do you identify yourself? (check all that apply)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> a. White            | <input type="checkbox"/> c. Asian/Pacific Islander | <input type="checkbox"/> e. Other _____ |
| <input type="checkbox"/> b. African-American | <input type="checkbox"/> d. Latino/Hispanic        | _____                                   |

**6. Gender:**

- a. Male       b. Female

**Adolescent Module**

**1. Accessing Services**

Program Recruited from: \_\_\_\_\_

Date: \_\_\_\_\_

**Trans-  
portation**

1. How did you get here today?

- a. subway/bus       c. given ride      e. bike      g. other: \_\_\_\_\_  
 b. drive       d. walk      f. cab

2. Where were you coming from?

- a. home       b. school       c. work       d. other: \_\_\_\_\_

3. How long did it take to get here?

\_\_\_\_\_ minutes

**Previous  
Visits**

4. Is this the first time you have come here for services/for the program?

- a. Yes       b. No

5. Approximately, how many times have you been here in the last year?

\_\_\_\_\_ times including this time

**Referral  
Source**

6. How did you find out about these services? (check all that apply)

- a. don't know/don't remember       e. health professional referral  
 b. friend       f. family (relationship): \_\_\_\_\_  
 c. advertisement       g. staff from this program  
 d. through adult at school       h. other: \_\_\_\_\_

7. Did you have an appointment to come in today?

- a. Yes       b. No

**Reason  
for  
Appoint-  
ment**

8. What kind of appointment was it? Was it...(read all options) (check all that apply)

- a. don't know       c. sports physical       e. check-up/ well-visit       g. other: \_\_\_\_\_  
 b. sick care       d. immunization       f. no appointment, walk-in \_\_\_\_\_

## 2. Clients' Opinions about the Program

---

- Reason for Choosing**
1. What are the main reasons you chose to come here instead of another clinic? (check all that apply)
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> a. no reason           | <input type="checkbox"/> e. like the staff           | <input type="checkbox"/> i. don't know any other place |
| <input type="checkbox"/> b. convenient hours    | <input type="checkbox"/> f. confidentiality/privacy  | <input type="checkbox"/> j. other: _____               |
| <input type="checkbox"/> c. convenient location | <input type="checkbox"/> g. teens are welcome here   | _____  |
| <input type="checkbox"/> d. free/low cost       | <input type="checkbox"/> h. someone referred me here |  |

- Program Strengths**
2. What do you like most about these services? (check all that apply)
- |   |   |
|---|---|
| <input type="checkbox"/> a. nothing in particular                 | <input type="checkbox"/> g. good quality care/gets the help needed      |
| <input type="checkbox"/> b. easy to make an appointment           | <input type="checkbox"/> h. feels privacy or confidentiality is assured |
| <input type="checkbox"/> c. can walk-in and see someone that day  | <input type="checkbox"/> i. has a regular relationship with a provider  |
| <input type="checkbox"/> d. short waiting times                   | <input type="checkbox"/> j. like the staff                              |
| <input type="checkbox"/> e. free/low cost                         | <input type="checkbox"/> k. other: _____                                |
| <input type="checkbox"/> f. can get many things done at one place |   |

- Program Weaknesses**
3. What do you like least about these services? (check all that apply)
- |   |   |
|---|---|
| <input type="checkbox"/> a. nothing in particular             | <input type="checkbox"/> g. quality of care is not high           |
| <input type="checkbox"/> b. difficult to make an appointment  | <input type="checkbox"/> h. worried about privacy/confidentiality |
| <input type="checkbox"/> c. no walk in for same day service   | <input type="checkbox"/> i. no regular relationship w/ provider   |
| <input type="checkbox"/> d. long waiting times                | <input type="checkbox"/> j. dislike the staff                     |
| <input type="checkbox"/> e. cost of services                  | <input type="checkbox"/> k. other: _____                          |
| <input type="checkbox"/> f. limited services at this location |   |

- Other Services**
4. Are there other services you would like to have available when you come here? (check all that apply)
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> a. nothing                 | <input type="checkbox"/> f. pregnancy testing        | <input type="checkbox"/> k. substance use services       |
| <input type="checkbox"/> b. condoms                 | <input type="checkbox"/> g. STD testing              | <input type="checkbox"/> l. violence prevention services |
| <input type="checkbox"/> c. other birth control     | <input type="checkbox"/> h. HIV testing              | <input type="checkbox"/> m. one-on-one mental health     |
| <input type="checkbox"/> d. emergency birth control | <input type="checkbox"/> i. contraceptive counseling | <input type="checkbox"/> n. primary care services        |
| <input type="checkbox"/> e. abortion services       | <input type="checkbox"/> j. abortion counseling      | <input type="checkbox"/> o. place to hang out            |
|   |  | <input type="checkbox"/> p. other: _____                 |

- Refer a Friend**
5. Would you recommend this program to a friend?
- a. Yes       b. No

If Yes...

- 5A. For which services?
- |  |   |
|--|---|
| <input type="checkbox"/> a. Don't know | <input type="checkbox"/> b. All services in general                         |
| <input type="checkbox"/> c. STD        | <input type="checkbox"/> d. HIV <input type="checkbox"/> e. Family Planning |

6. Have you ever recommended this place to a friend?
- a. Yes       b. No

**3. General Barriers to Care and Teen Friendliness Issues**

**Barriers**

1. What do you think are the major barriers for adolescents when accessing sexual and reproductive health care? (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> a. none                          | <input type="checkbox"/> i. hard to talk about these topics  |
| <input type="checkbox"/> b. paying for services           | <input type="checkbox"/> j. unsupportive parents/adults      |
| <input type="checkbox"/> c. lack of transportation        | <input type="checkbox"/> k. don't want parents to find out   |
| <input type="checkbox"/> d. don't know where to go        | <input type="checkbox"/> l. don't want friends to know       |
| <input type="checkbox"/> e. services are unavailable      | <input type="checkbox"/> m. don't want to be judged          |
| <input type="checkbox"/> f. fear of clinic procedures     | <input type="checkbox"/> n. in denial about own health risks |
| <input type="checkbox"/> g. finding a provider they trust | <input type="checkbox"/> o. other: _____                     |
| <input type="checkbox"/> h. no place specific for teens   |  |

**Staff Qualities**

2. What is important to you about the type of people who work in a place like this and how they treat teens? (check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> a. nothing/don't know              | <input type="checkbox"/> f. respects my privacy     |
| <input type="checkbox"/> b. same gender as me               | <input type="checkbox"/> g. respects me/my opinion  |
| <input type="checkbox"/> c. same race/ethnicity as me       | <input type="checkbox"/> h. dependable/trust worthy |
| <input type="checkbox"/> d. can relate to me/ understanding | <input type="checkbox"/> i. kind/nice               |
| <input type="checkbox"/> e. competent/good at what they do  | <input type="checkbox"/> j. other: _____            |

**Restructure/Expand**

3. Pretend that you are in charge of a program like this for teens. If you could design the program any way you wanted, what would be the most important things you would include?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Please rate which of the following elements would be important to include. Please check how important this component would be to you:

	<b>(1) Optional</b>	<b>(2) Helpful, but not vital</b>	<b>(3) Very important to include</b>
<b>a. Provide more services</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>b. Expand/repeat this program</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<b>(1) Optional</b>	<b>(2) Helpful, but not vital</b>	<b>(3) Very important to include</b>
<b>c. Offer a mix of services</b>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<b>d. Give more health information</b>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<b>e. Relate services to my life</b>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<b>f. Have clinic staff spend more time with teens</b>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<b>e. Have clinic staff treat teens better</b>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<b>e. Offer more services for males</b>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<b>e. Let teens decide how programs are run</b>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<b>e. Other:</b>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____

**4. Missed Opportunities & Knowledge of Services**

**The Visit**

*The next few questions ask about your experience receiving health care and what the doctor or nurse talked with you about.*

1. During your visit today, did a health care provider ask you if you were sexually active?

- a. Yes                       b. No                       c. Don't remember

At this visit,	did you talk about...	b. Who brought the subject up?
<b>2. Sexually transmitted diseases</b>	<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't remember	<input type="checkbox"/> a. I did <input type="checkbox"/> b. Provider <input type="checkbox"/> c. Don't remember
<b>3. HIV/AIDS</b>	<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't remember	<input type="checkbox"/> a. I did <input type="checkbox"/> b. Provider <input type="checkbox"/> c. Don't remember
<b>4. Birth control</b>	<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't remember	<input type="checkbox"/> a. I did <input type="checkbox"/> b. Provider <input type="checkbox"/> c. Don't remember

**Usual Place of Care**

5. Where do you usually go when you need medical care?

- a. no regular place                       d. managed care clinic                       g. school clinic  
 b. this is my regular source                       e. public clinic                       h. emergency room  
 c. private doctor                       f. community clinic                       h. other: \_\_\_\_\_

6. The last time you went for care at your "regular" source of care (including this clinic), did a health care provider ask you if you were sexually active?

- a. Yes                       b. No                       c. Don't remember

At that visit did you talk about...	b. Who brought the subject up?
<b>7. Sexually transmitted diseases</b>	<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't remember
<b>8. HIV/AIDS</b>	<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't remember
<b>9. Birth control</b>	<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't remember

**Service Utilization**

The next group of questions ask about where you would go or recommend that a friend go for different types of health services.

<b>If you or your friend needed...</b>	<b>10. Where could you/they go?</b>	<b>11. Can you come to this place (where you are now) for that service?</b>
<b>a. to get condoms</b>		<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't know
<b>b. to get other types of birth control</b>		<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't know
<b>c. to get a pregnancy test</b>		<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't know
<b>d. to get an STD test</b>		<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't know
<b>e. to get an HIV test</b>		<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't know
<b>f. to get emergency contraception</b>		<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't know
<b>g. choosing a birth control method</b>		<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't know
<b>h. to discuss prenatal care/adoption or abortion</b>		<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't know
<b>i. to discuss getting an abortion</b>		<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't know
<b>j. to discuss placing a child for adoption</b>		<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't know
<b>k. to discuss risks of unprotected sex</b>		<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't know
<b>l. to discuss gay, lesbian , bisexual, or transgender issues</b>		<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't know



**Talks to Others**

5. For each of the following topics, is there somebody other than your parents/(fill in guardian relationship) you would want to talk to if you had a concern about it?

	<b>a. Doesn't talk to anyone</b>	<b>b. Adult Relative</b> (write in relationship)	<b>a. Other Adult</b> (write in relationship)	<b>d. Friend</b>
<b>a. Sex</b>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>
<b>b. Using contraception</b>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>
<b>c. STD testing &amp; treatment</b>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>
<b>d. HIV/AIDS risks or testing</b>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>
<b>e. Discussing about Pregnancy/ Abortion/ Adoption</b>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>

6. Is there anything else you wish you could talk about more with other people?

## 6. Conclusion and Demographics

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1. That was the last question. Is there anything else you think we should know that is important to help understand teens' sexual and reproductive health needs?

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2. What is your Gender?

- a. Male       b. Female

3. How old are you?

\_\_\_\_\_ years

4. With what race-ethnicity do you identify?

- a. White                       c. Asian/Pacific Islander       e. Other \_\_\_\_\_  
 b. African-American       d. Latino/Hispanic              \_\_\_\_\_

**Structural Survey Module: Clinical Setting—  
1. Client Demographics**

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Program Name \_\_\_\_\_

Name of person who completed this questionnaire:  
\_\_\_\_\_

Position: \_\_\_\_\_ Phone #: \_\_\_\_\_

The following are questions about the clients your agency serves.

How many clients do you serve per month? \_\_\_\_\_

**1. Gender:** a. Male \_\_\_\_\_ % b. Female \_\_\_\_\_ %

**2. Age Range:** \_\_\_\_\_

**3. Proportion by age in years:**

a. <14 \_\_\_\_\_ % b. 15-19 \_\_\_\_\_ % c. 20-24 \_\_\_\_\_ %  
d. 25-29 \_\_\_\_\_ % e. 30+ \_\_\_\_\_ %

**4. Race-ethnicity:** a. White \_\_\_\_\_ % b. African-American \_\_\_\_\_ %  
c. Asian/Pacific Islander \_\_\_\_\_ % d. Latino/Hispanic \_\_\_\_\_ %  
e. Native American \_\_\_\_\_ % e. Other \_\_\_\_\_ %

**5. What proportion of your adolescent clients require services offered in languages other than English:**

a. Spanish \_\_\_\_\_ % b. Tagalog \_\_\_\_\_ %  
c. Cantonese \_\_\_\_\_ % d. Other \_\_\_\_\_

**6. What is the income eligibility criteria for the clients you serve:**

- a. None  b. <100% of poverty level  
 c. <150% of poverty level  
 d. <200% of poverty  
 e. Other : \_\_\_\_\_

**7. Proportion by type of payment:**

a. Medicaid \_\_\_\_\_ % f. Self \_\_\_\_\_ %  
b. Title X \_\_\_\_\_ % g. Other \_\_\_\_\_ %  
c. Other Family Planning Program \_\_\_\_\_ %  
d. State STD Funds \_\_\_\_\_ %  
e. Other State Funds \_\_\_\_\_ %

**8. How are services promoted or advertised among adolescents?(check all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> a. yellow pages                 | <input type="checkbox"/> f. health fairs/events                        |
| <input type="checkbox"/> b. ads in public transportation | <input type="checkbox"/> g. presentations in classrooms                |
| <input type="checkbox"/> c. newspaper ads                | <input type="checkbox"/> h. community health outreach workers(CHOW)    |
| <input type="checkbox"/> d. radio spots                  | <input type="checkbox"/> i. Web page for agency                        |
| <input type="checkbox"/> e. flyers                       | <input type="checkbox"/> j. "My Space" or other internet communication |
|  | <input type="checkbox"/> k. other: _____                               |

**Structural Survey Module –  
2. Availability and Scope of Clinical Services**

**Scope of Services**

1. Please make an “X” in the appropriate boxes, to indicate the scope of services offered to adolescents:

Services available:	On-site	Through referral	Services Available:	On-site	Through referral
a. Primary care			i. Pregnancy testing		
b. Acute care			j. Emergency contraception		
c. Prenatal care			k. Abortion counseling/information		
d. Pap smear			l. Abortion		
e. Sports Physicals			m. STD education/health promotion		
f. Pregnancy prevention education			n. STD client-centered counseling		
g. Contraceptive counseling			r. STD partner notification/treatment		
h. Contraceptive dispensing			o. HIV education/health promotion		
i. Birth control pills			p. HIV counseling/testing		
ii. Norplant			q. HIV clinical care		
iii. Depo Provera			s. Violence prevention counseling		
iv. Condoms			t. Substance use		
v. IUD			u. Mental health		
vi. Other (specify):			v. Other (specify):		

2. Please make an “X” if the following STD services are available on-site or through referral .

	a. Screening		b. Offers Urine-based tests	c. Diagnosis & Treatment		d. Partner Services notification & treatment		e. Lab test Processing	
	On site	Refer-ral		On site	Refer-ral	On site	Refer-ral	On site	Refer-ral
1. Bacterial Vaginosis									
2. Chlamydia									
3. Genital Herpes									

	a. Screening		b. Offers Urine-based tests	c. Diagnosis & Treatment		d. Partner Services notification & treatment		e. Lab test Processing	
4. Gonorrhea									
5. Hepatitis B									
6. Human Papilloma Virus									
7. Syphilis									
8. Trichomoniasis									
9. Other:									

10. For services that are not provided by this program, how are referrals made? (check all that apply)

- a. Teen receives contact information for place of referral
- b. Call is made by program to referral agency to alert them of referral
- c. Letter or email is sent to referral agency to alert them of referral
- d. Program assists teen in making an appointment with referral agency
- e. Follow-up is done to confirm teen was seen by referral agency
- f. Other \_\_\_\_\_

11. Do you provide any STD detection or treatment services outside of clinic facilities (for example, a mobile van or other community setting)?

- a. Yes
- b. NO

**If yes,**

	For Males Teens		For Female Teens	
11a. For which diseases?	<input type="checkbox"/> a. Chlamydia	<input type="checkbox"/> b. Gonorrhea	<input type="checkbox"/> c. Chlamydia	<input type="checkbox"/> d. Gonorrhea
11b. Using urine based tests?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11c. In what type of locations?	<input type="checkbox"/> a. Mobile Vans <input type="checkbox"/> b. Malls <input type="checkbox"/> c. Parks <input type="checkbox"/> d. Other:			

12. For services that are not provided by this program, how are referrals made? (check all that apply)

- a. Teen receives contact information for the referral agency
- b. Program assists teen in making an appointment with referral agency
- c. Notification is sent by program to referral agency to alert them of referral
- d. Follow-up is done to confirm teen was seen by referral agency
- e. Other \_\_\_\_\_

**Service Availability**

1. Please enter the times that services are offered to teen clients. Please put a star (\*) next to the time(s) client volume is heaviest.

a. STD services:		b. HIV services:		c. Family Planning Services:	
Mon	_____ to _____	Mon	_____ to _____	Mon	_____ to _____
Tues	_____ to _____	Tues	_____ to _____	Tues	_____ to _____
Wed	_____ to _____	Wed	_____ to _____	Wed	_____ to _____
Thurs	_____ to _____	Thurs	_____ to _____	Thurs	_____ to _____
Fri	_____ to _____	Fri	_____ to _____	Fri	_____ to _____
Sat	_____ to _____	Sat	_____ to _____	Sat	_____ to _____
Sun	_____ to _____	Sun	_____ to _____	Sun	_____ to _____

2. Do you serve adolescents through:

- a. special hours for teens
- b. both special hours for teens and regular hours for all ages
- c. only regular hours, no special hours for teens

3. In what languages, besides English, are services offered:

- a. None
- b. Spanish
- c. Tagalog
- d. Cantonese
- e. Other : \_\_\_\_\_

4. What type of public transportation is available to the program or facility?

A. Bus line

- a. Yes
- b. No

If yes, walking distance from bus stop to facility \_\_\_\_\_ minutes

B. Subway/BART/Train

- a. Yes
- b. No

If yes, walking distance from station to facility \_\_\_\_\_ minutes

5. Does your program offer its clients any incentives or assistance with transportation costs?

- a. Yes
- b. No

If yes, what type of incentive or assistance? \_\_\_\_\_

**Structural Survey Module –  
3. Availability and Scope of Non-Clinical Services**

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**Scope of Services:**

1. How long are teens clients involved in program/services: (mark all that apply)

- a. as long as teen chooses                       d. one-time individual counseling session  
 b. one-time educational presentations         e. series of counseling sessions: \_\_\_\_\_# of hrs  
 c. series of presentations: \_\_\_\_\_# in series, Length? \_\_\_\_\_hours     f. other: \_\_\_\_\_

2. Please make an “X” in the appropriate boxes, to indicate the scope of services offered to adolescents:

	On-site	Through referral		On-site	Through referral
a. Pregnancy prevention education			i. Youth advocacy		
b. STD education/health promotion			j. Leadership training		
c. HIV education/health promotion			k. Job training		
d. Contraceptive counseling			l. Parent-child counseling		
e. Abortion counseling/information			m. Communication skill building		
f. Substance use counseling			n. Recreation		
g. Mental health services			o. Other:		
h. Violence prevention counseling					

3. For services that are not provided by this program, how are referrals made? (check all that apply)

- a. Teen receives contact information for referral agency  
 b. Program assists teen in making an appointment with referral agency  
 c. Notification is sent by program to referral agency to alert them of referral  
 d. Follow-up is done to confirm teen was seen by referral agency  
 e. Other \_\_\_\_\_

**Peer Education Outreach Program: (Only for those using peer education as a program components)**

**4. What selection criteria do you use for peer educators? (check all that apply)**

- a. academic standing/GPA       f. geographic region \_\_\_\_\_  
 b. high risk youth               g. age \_\_\_\_\_  
 c. pregnant/parenting teens     h. other: \_\_\_\_\_  
 d. referrals from other program  
 e. males

**5. How much time is required to commit to program?**

\_\_\_ hours per week  
\_\_\_ days per week

**6. How long do peer educators participate in program?**

- a. one semester     b. one year     c. indefinite     d. other: \_\_\_\_\_

**7. How many peer educators participate at one time? \_\_\_\_\_**

**8. Are the peer educators paid?  a. Yes  b. No**

If yes, how much \$\_\_\_/hour or \$\_\_\_/month or \$\_\_\_\_\_

**9. Do peers receive any other kind of incentive?**

- \_\_\_ a. Class Credit      \_\_\_ b. Volunteer Hours      \_\_\_ c. Other: \_\_\_\_\_

**10. How long is the training for peer educators?**

- \_\_\_ a. hours       \_\_\_ b. hours + ongoing training  
 \_\_\_ c. days       \_\_\_ d. days + ongoing  
 e. ongoing       f. other: \_\_\_\_\_

**Structural Survey Module –  
4. Funding Sources - Clinical**

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1. Please provide an approximate breakdown of your organization’s total budget by funding source:

Source	Approx. %	Sources	Approx. %	Sources	Approx. %
a. CDC		e. EPSDT		i. Foundations	
b. Title X		f. Private Insurance		j. Donations - e.g., United Way, individual contributors...	
c. Family PACT		g. Client Self-pay		k. Other (specify)	
d. Medicaid		h. County			

2. How do teens pay for services?(please check all that apply)

- a. all services are free for teens
- b. co-payment up to \$ \_\_\_\_\_
- c. sliding scale
- d. private insurance
- e. Kaiser or other HMO
- f. public funding, such as Medicaid
- g. Other \_\_\_\_\_

3. If teens are unable to pay, are they still able to receive services?

- a. Yes
- b. No
- c. All services are free

**Structural Survey Module –  
5. Practice Guidelines and Policies – Clinical Programs**

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**Practice Guidelines:**

1. Are clinical practice guidelines (standards, operating procedures) used in your program?

- a. Yes  b. No

If yes, which ones? (check all that apply)

- a. Guide to Clinical Prevention Services, Public Health Service  
 b. STD Treatment Guidelines, Centers for Disease Control and Prevention  
 c. Bright Futures, Maternal and Child Health Bureau, Health Resources and Services Administration  
 d. AMA Guidelines for Adolescent Preventive Services (GAPS)  
 e. American College of Obstetrics & Gynecology  
 f. Developed in-house  
 g. HEDIS measures  
 h. Other (describe): \_\_\_\_\_

2. If these clinical practice guidelines were developed in house, how were they developed and reviewed? (mark all that apply)

- a. internal staff committee/workgroup  c. external review  
 b. external consultant  d. Other: \_\_\_\_\_

**Sexual and Reproductive Health Screening:**

3. What proportion of your patients coming to your clinic for non-reproductive health services receive the following screenings:

- a. Sports physicals \_\_\_\_\_%  
 b. Annual check-up \_\_\_\_\_%  
 c. Drop in for primary care (for example, flu) \_\_\_\_\_%  
 d. Immunizations (other than HPV) \_\_\_\_\_%  
 e. Emergency care \_\_\_\_\_%  
 f. Other type of visit \_\_\_\_\_%

**Confidentiality:**

4. Is confidentiality for teens mentioned in advertisements/outreach material used by your program?

- a. Yes                       b. No

5. Are procedures in place to assure confidentiality to teens? If yes, please describe:

A. Billing:

- a. NA                       b. No                       c. Yes \_\_\_\_\_

B. Providing Test Results

- a. NA                       b. No                       c. Yes \_\_\_\_\_

C. Appointment Reminders

- a. NA                       b. No                       c. Yes \_\_\_\_\_

D. Medical Records

- a. NA                       b. No                       c. Yes \_\_\_\_\_

E. Other Procedures:

- a. NA     b. No                       c. Yes \_\_\_\_\_

6. Does your data system have any features that assists in protecting the confidentiality of your teen clients?

- a. Yes                       b. No

If yes, please describe briefly:

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**Systemic Integration:**

7. Are data on Family planning, STD, and HIV related services linked in such a way that a comprehensive medical history of each patient is readily available to providers across different departments or clinics?

- a. NA                       b. No                       c. Yes

If yes, which of the following service areas are integrated?

- a. STD                       b. HIV  
 c. Family Planning                       d. Other \_\_\_\_\_

**Structural Survey Module –  
6. Staffing – Clinical Programs**

1. Please fill in the number of full time equivalents (FTEs) for each type of staff in your program.

<b>Support Staff:</b>	<b>#FTE</b>		<b>#FTE</b>		<b>#FTE</b>
a. Eligibility Worker		c. Medical Records		e. Other (specify):	
b. Receptionist		d. Laboratory Technician			
<b>Provider Staff:</b>	<b>#FTE</b>		<b>#FTE</b>		<b>#FTE</b>
f. MD		i. Social Worker		l. Disease Intervention Specialist	
g. Mid-level Practitioner (PA, NP)		j. Counselor (MFCC)		m. Outreach Worker/Community Health Outreach Worker	
h. Nurse		k. Health Educator		o. Other (specify):	

2. Please describe the racial-ethnic diversity of your staff in raw numbers.

	White	African American	Hispanic / Latino	Asian/Pacific Islander	Other:
a. Support Staff	%	%	%	%	%
b. Service Providers	%	%	%	%	%

3. Place an “X” in the appropriate boxes showing which staff conduct each activity with teen clients.

	MD.	Mid-level Practitioner	Nurse	Social Worker	Counselor	Health Educator	Lab Tech	Other (Specify)
a. Health Education								
b. STD risk assessments								
c. Clinical Services								

**Structural Survey Module: 6. Staffing – Clinical Programs**

	<b>MD.</b>	<b>Mid-level Practitioner</b>	<b>Nurse</b>	<b>Social Worker</b>	<b>Counselor</b>	<b>Health Educator</b>	<b>Lab Tech</b>	<b>Other (Specify)</b>
<b>d. Partner Notification &amp; Treatment</b>								
<b>e. CHOW= Community Health Outreach Worker</b>								
<b>f. Teen Peer Educator</b>								
<b>g. Lab Tests – On-Site</b>								
<b>h. Other</b>								

**Structural Survey Module –  
7. Staffing – Non-Clinical Programs**

1. Please fill in the number of full time equivalents (FTEs) for each type of staff in your program

<b>Support Staff:</b>		<b>#FTE</b>	<b>#FTE</b>		<b>#FTE</b>
a. Eligibility Worker			c. Other (specify):		
b. Receptionist					
<b>Provider Staff:</b>		<b>#FTE</b>	<b>#FTE</b>		<b>#FTE</b>
d. Social Worker			g. Program Coordinator		j. Community Volunteers
e. MFCC Counselor			h. Health Educator		k. Other (please specify):
f. Other Counselor		i. CHOW= Community Health Outreach Worker			

2. Please describe the racial-ethnic diversity of your staff in raw numbers.

	White	African American	Hispanic / Latino	Asian/Pacific Islander	Other:
a. Support Staff	%	%	%	%	%
b. Service Providers	%	%	%	%	%

3. Which type of staff conduct the following sexual and reproductive health activities for teens?

	Project Coordinator	Social Worker	MFCC Counselor	Other Counselor	Health Educator	CHOW*	Volunteer	Other (Specify)
a. Health Education								
b. STD risk assessments								
c. Training peer educators								
f. Other								

\* Community Health Outreach Worker

**Provider Module – Teen Friendliness Inventory – Short Survey**

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1. For the teens that you serve, what aspects of your program are you most proud of in meeting adolescents’ sexual and reproductive health needs? (check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> a. creating a teen friendly environment    | <input type="checkbox"/> g. ability to retain teen clients          |
| <input type="checkbox"/> b. providing high quality of services      | <input type="checkbox"/> h. strong links w/ other service providers |
| <input type="checkbox"/> c. comprehensive scope of services         | <input type="checkbox"/> i. provider-client relationship            |
| <input type="checkbox"/> d. providing confidential services         | <input type="checkbox"/> j. improving parent-child communication    |
| <input type="checkbox"/> e. using innovative outreach strategies    | <input type="checkbox"/> k. support from community                  |
| <input type="checkbox"/> f. partner notification/treatment services | <input type="checkbox"/> l. Other: _____                            |

**Provider Demographics:**

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2. What is your specific area of education or training?

- |        |   |         |   |
|--------|---|---------|---|
| MD:    | <input type="checkbox"/> a. Adolescent Medicine   | Masters | <input type="checkbox"/> g. Social Work                 |
|        | <input type="checkbox"/> b. OB/GYN                | Level:  | <input type="checkbox"/> h. Marriage & Family Counselor |
|        | <input type="checkbox"/> c. Other MD: _____       |         | <input type="checkbox"/> i. Public Health               |
| Mid    | <input type="checkbox"/> d. Nurse Practitioner    | Comm/   | <input type="checkbox"/> j. Health Education            |
| Level: | <input type="checkbox"/> e. Registered Nurse      | Educ:   | <input type="checkbox"/> k. Outreach Worker             |
|        | <input type="checkbox"/> f. Physician’s Assistant | Other:  | <input type="checkbox"/> l. _____                       |

3. How many years have you been providing services to adolescents?

\_\_\_\_\_ years

4. What year did you complete your professional training?

Year: \_\_\_\_\_

5. How old are you?

- |                                      |                                   |
|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> a. Under 25 | <input type="checkbox"/> e. 41-45 |
| <input type="checkbox"/> b. 25-30    | <input type="checkbox"/> f. 46-50 |
| <input type="checkbox"/> c. 31-35    | <input type="checkbox"/> g. 51-55 |
| <input type="checkbox"/> d. 36-40    | <input type="checkbox"/> h. 56-60 |
|                                      | <input type="checkbox"/> i. 61+   |

6. With what race-ethnicity/ies do you identify yourself?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> a. White            | <input type="checkbox"/> c. Asian/Pacific Islander | <input type="checkbox"/> e. Other _____ |
| <input type="checkbox"/> b. African-American | <input type="checkbox"/> d. Latino/Hispanic        | _____                                   |

7. What is your gender?

- a. Male  b. Female